MARCH // APRIL 2014

FAMILY THERAPY

THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

Diverse Families

What do today's families look like?

Checking multiple boxes:
Understanding the challenges
and strengths of multiracial families
page 22

Three's no longer a crowd:
Considerations for working with
polyamorous families
page 28

Same-sex Parenthood: Amidst
challenges and obstacles, their
numbers have doubled in a decade,
and the future's looking bright.
page 36

VOLUME 13, NUMBER 2

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FAMILY THERAPY

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How does one define "family"? Is it by a recognized structure, shared residence, time invested, shared resources, or blood and legal ties? Each of these presents unique challenges, leaving out large numbers of people who identify themselves as family members. It is important for us as therapists to explore our thoughts on how families should be discussed, portrayed, and perceived, for our practices, as well as our personal lives.
Robin Milhausen, PhD *Ruth Neustifter, PhD*

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The way in which we are called to do therapy is changing. Diverse families like same-sex couples are dealing with issues of adoption, surrogacy, custody concerns, parental roles, and much more. More than ever, families need informed and competent mental healthcare providers.
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LETTERS TO THE EDITOR

We encourage members' feedback on issues appearing in the Family Therapy Magazine. Letters should not exceed 250 words in length, and may be edited for grammar, style and clarity. We do not guarantee publication of every letter that is submitted. Letters may be sent to FTM@aamft.org or to Editor, Family Therapy Magazine, 112 South Alfred Street, Alexandria, VA 22314-3061.

[a message from the executive director]

Diversity: Challenges and Rewards

The reality of achieving diversity is challenging.

It takes work to tolerate viewpoints you oppose. It takes work to be sensitive to issues you may find unfamiliar. It takes work to be receptive to behaviors you perceive as offensive.

These challenges are at the very core of this profession. Every day we are charged with helping others to listen, understand, and maybe even change viewpoints or behaviors. We, too, must be mindful and reflect upon our biases as these same challenges face the profession, the Association, and each of us personally.

AAMFT has a rich and storied history of including professionally heterogeneous voices that contributed to the systemic perspective. As an organization, however, we have struggled to keep pace with the changing demographics of society reflecting ethnic and cultural diversity.

A stated core value of AAMFT is the acceptance, appreciation, and inclusion of a diverse membership. The Association believes that the depth of conversation and dialogue in our field comes from multiple voices and perspectives. In the last issue of *Family Therapy*, AAMFT examined diversity among religious and spiritual beliefs. In 2005, we published an issue of *FTM* on diversity related to sexual orientation and categorization. Today, we revisit similar, but different, diversity topics:

- Diversity in Today's Families
- Departures from Monogamy
- Working with Multiracial Individuals and Families: Increasing Our Understanding
- Insights to Transgendered Youth
- Defining the LGBTQ Family (And Being Content Without an Answer)

Examining some of the more unique situations our profession faces today regarding diversity, including how it is defined by today's families, helps us increase our understanding of diverse groups.

In their article about working with Muslim families, Daneshpour and Dadras (2014, p. 23) emphasize, "…when groups are discussed, it is difficult not to subtly adopt a stereotypic approach." Each of us, depending upon the circumstance, is both "on the inside looking out" and the "outside looking in." Yet, without understanding and compassion, we can never completely help those in need nor totally welcome those different than ourselves. The recursive coin of diversity requires compassion, reflection, and action.

Our 2012 all member survey (*FTM*, 2012) reveals some very hopeful trends on the Association's growth in diversity. Realizing that Clinical Members* represent the current professionals delivering

While the effort to achieve a rich focus on increasing knowledge of diverse groups will always be an ongoing one for the Association, these recent initiatives have represented positive steps:

- More in-depth efforts to raise awareness of AAMFT's Minority Fellowship Program resulting in an increase of nearly 200% in application rates from 2007 through 2014.
- Courses developed for AAMFT's Teneo online learning system that focus on working with LGBTQ clients, as well as race and ethnicity issues from a systems perspective.
- Open discussion on LGBTQ youth issues at our 2013 Annual Conference with nearly 100 participants.
- Advanced clinical training on spirituality offered via our 2014 Institutes.
- Recognition through AAMFT Student Minority Awards of individuals actively intervening with social justice and inclusiveness in areas of supervision, schools, and military families.

Have ideas on how AAMFT can continue to encourage conversation, learning, and understanding about diversity issues? Post your ideas in the AAMFT Community. www.aamft.org/Community

services and student members represent the future of marriage and family therapists delivering services, it is exciting to see that 27% of student members self-identified as an ethnic minority, compared to only 9% of Clinical Members. Likewise, 9.48% of student members identified as African American as compared to 1.9% of Clinical Members; 4.66% student members identified as Asian, compared to 2.3% of Clinical Members; 5.92% student members identified as Hispanic, compared to 2.8% of Clinical Members. Despite knowing that it is common for the "membership pipeline" to experience attrition, AAMFT's increasing diversification is beginning to reflect some similarity to societal shifts.

Anecdotally, similar increases are noticed within other diverse identifications such as sexuality and religion. This increased diversity suggests that marriage and family therapists might be moving out of a relatively homogenous make-up to one that provides a better fit between AAMFT members and the changing societal family dynamics and demographics.

At a recent Minority Fellowship training, in addition to seeing excitement about their education and witnessing some outstanding professional development, it was encouraging to hear young professionals commenting on the systemic nature of diversity. Barriers and impediments related to diversity in AAMFT were discussed, but so were solutions and personal agency. Analogous to a family, I heard one student comment something along the lines, "We're not perfect, but we are family. We all have a role to help us grow and thrive."

Blumer, Haym, Zimmerman and Prouty (2014, p. 32) discuss how institutions can create "walls of invisibility around individuals" Whether it is working to streamline the student to Clinical Fellow process or finding nuances in membership benefits suggesting exclusivity or having candid conversations about systemic barriers, everyone has some responsibility to breakdown walls of invisibility that limit growth, health and prosperity.

Diversity is challenging. Yet, removing barriers, opening opportunities, and attaining inclusion are richly rewarding. Achieving these necessary goals requires that each of us inquires appreciatively, practices tolerant understanding, and shows charity with attribution to both sides of the recursive coin.

—**Tracy Todd, PhD**

**Clinical Member was the membership category in 2012 equivalent to AAMFT's current Clinical Fellow category.*

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Blumer, M., Hyam, C., Zimmerman, K., & Prouty, A. (2014). What's one got to do with it? Considering monogamous privilege. *Family Therapy*. March/April, 33.

Daneshpour, M. & Dadras, I. (2014). Eccentric perspective: Considering spirituality in working Muslim families. *Family Therapy*, January/February, 23.

Todd, T., & Holden, E. (2012). Membership survey report. *Family Therapy*, September/October, 13-14.

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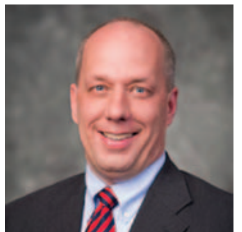
noteworthy

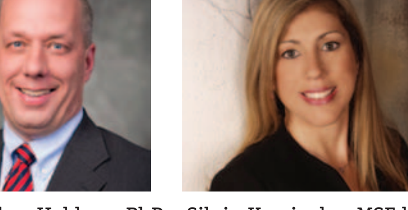
AAMFT announces the 2014 Preliminary Slate:

The AAMFT Elections Council met February 28 – March 1. After reviewing many qualified candidates, the Council is pleased to announce the preliminary slate for the 2014 elections. Ballots will be sent in June. There were a total of 29 nominees for the various positions.

President (President-Elect)



Christopher Habben, PhD



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Secretary

Roberta Crockett, MA

Thomas Smith, PhD

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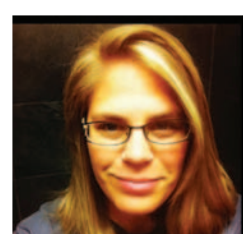


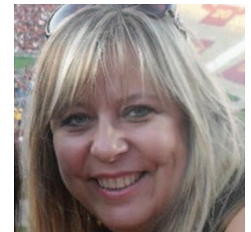
Kristina Brown, PhD

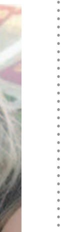
Daniel Lord, PhD

Megan Murphy, PhD

Board

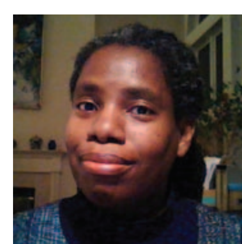
Samuel Berg, DMin





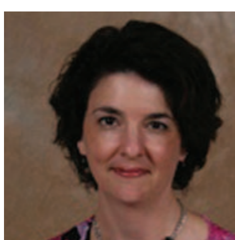
Marj Buchholz, MS

William Northey, PhD



Karen Westbrooks, PhD

Elections Council



Laura Bryan, PhD

Kathleen Burns-Jager, PhD

Jeffrey Jackson, PhD

Kenneth Phelps, PhD

Awareness Dates

MAY 1-31

Mental Health Month
Mental Health America
rbridge@mentalhealthamerica.net
www.mentalhealthamerica.net/go/may

MAY 4-10

Children's Mental Health Awareness Week
National Federation of Families for Children's Mental Health
ffcmh@ffcmh.org
www.ffcmh.org

Therapy Topics for consumers can be found at www.aamft.org/therapytopics.asp.

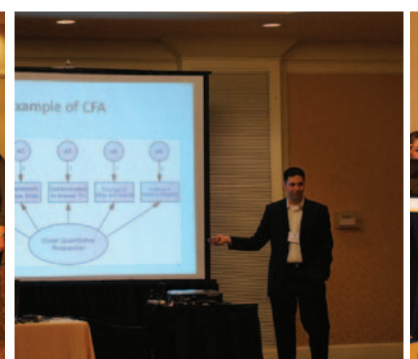
Institutes for Advanced Clinical Training

AAMFT's 2014 Institutes for Advanced Clinical Training was held March 6-9 in Baton Rouge, Louisiana. While the south was experiencing the effects of the cold weather that many of us have felt across the country, Baton Rouge still embraced attendees with the warmth and charm for which it is known. Attendees embraced the work hard, play hard theme of the Institutes by attending one of our "best of the best" educational opportunities during the day and, in the evenings, delighting in Cajun cuisine, space education at the downtown planetarium, touring exhibits of Chinese jade in the art museum, or just strolling along the banks of the Mississippi. As announced in the 2013 Annual Business Meeting, AAMFT is in the final stages of conducting a European feasibility study for the 2015 institutes and will be announcing its outcome and location in the near future! Get your passports ready and save the date for July 2015.

Scenes from the AAMFT Minority Fellowship Program Winter Training Institute

Held in February this year at the Hilton Arlington in Virginia, the Winter Training Institute featured interactive seminars and advanced workshops with distinguished scholars and clinicians in the behavioral health field of MFT. MFP Fellows meet to learn from, and interact with, presenters in the areas of culturally sensitive interventions with ethnic minority populations, as well as the integration of advanced quantitative research modalities. The MFP is a national workforce development program that seeks to, through collaboration with agencies like SAMHSA, and leading behavioral health professional associations like AAMFT, increase the number of culturally competent behavioral health practitioners who provide substance abuse and other mental health services to underserved minority populations. Through their continued participation in the MFP, Fellows help ensure the professional and academic advancement of the field of MFT for generations to come.

GoOnline For more information, visit www.aamft.org/mfp.



noteworthy

Leadership 2014

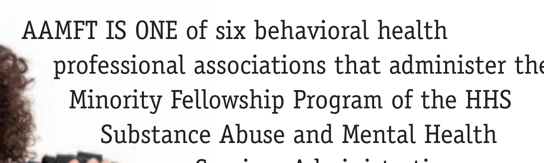
Leadership Conference 2014 was held March 13-16 in Arlington, VA. Leaders from 47 of AAMFT's 54 state and provincial divisions received information on real world, practical successes that demonstrated remarkable organization and use of member and material resources in reaching goals. Attendees discovered that focusing effort and resources on sometimes small but well-developed activities can result in important outcomes that positively affect the well-being and growth of the profession and create value for members.

AAMFT brought back the popular Learning Labs we began in 2013. The 45-minute labs featured staff and member presenters who discussed social media, technology, marketing, increasing non-dues revenue, member engagement strategies and leading meetings. Attendees also made their annual foray to visit their Members of Congress to advocate for AAMFT's three priority issues: MFT inclusion in Medicare, MFT jobs in the VA, and continued funding of MFT student and faculty. To balance out the very hard work accomplished by all, conference participants were treated to an exciting bus tour of DC landmarks.

Thank you for a wonderful conference. The training was excellent, and all of us from Utah very much appreciate the hard work everyone puts in to make it such a great event.

- BENJAMIN ERWIN, PHD, LMFT
UAMFT PRESIDENT

Congress Increases Mental Health Minority Fellowship Program (MFP) Funding by 87%; AAMFT Minority Fellows Educate Congressional Staff on MFP's Value



AAMFT IS ONE of six behavioral health professional associations that administer the Minority Fellowship Program of the HHS Substance Abuse and Mental Health Services Administration (SAMHSA). In federal fiscal year 2013, the MFP received $5,717,000. Congress recently enacted the Consolidated Appropriations Act for fiscal 2014, which will provide $10,695,000 during that year (October 1, 2013 through September 30, 2014).

However, the funding increase for 2014 does not guarantee further increases in 2015 or later, or even that 2015 funding will not be cut. Congress must decide each year on funding levels, and if Congress does not act timely, the 2011 Budget Control law will reduce funding for all "discretionary" programs (including MFP) under a process called sequestration.

On February 7, 19 of AAMFT Minority Fellows visited Capitol Hill to educate the staff of six Congressional appropriations committee members, Sens. Blunt (R-MO), Feinstein (D-CA), Harkin (D-IA), Moran (R-KS), and Shaheen (D-NH), and Rep. McCollum (D-MN). Our Fellows noted their career plans and stated they are able to pursue helping ethnic-minority communities due to MFP funding.

AAMFT members wishing to support increasing funding for the Minority Fellowship Program may visit **http://www.congressweb.com/aamft/6.**

Veterans (VA) Health Legislation With MFT Intern Stipends Considered But Deferred By Full Senate

ONE OF SEVERAL problems that MFTs face at the federal Department of Veterans Affairs (VA) is that, by VA policy, MFT (and LPC) clinical interns never receive financial stipends during their internships, yet all psychology and most social work interns receive such stipends, which average $22,000 annually for psychology interns.

AAMFT, the California Association of Marriage and Family Therapists (CAMFT) and Professional Counseling groups have repeatedly urged VA to provide such stipends, but to no avail. Thus, these groups support Congressional bills to require VA to do so. This requirement is included in bills chief-sponsored by Sen. Tester (D-MT): S 1155; Senate VA Committee Chair Sanders (I-VT): S 1581, S 1950, and S 1982; and Rep. Kirkpatrick (D-AZ): HR 3499.

On February 25, VA Committee Chairman Sanders' S 1982, an "omnibus" bill with many other provisions, passed a procedural hurdle to be considered by the full Senate. However, S 1950 would cost about $21 billion over 10 years, and on February 27, the Senate was unable to reach a three-fifths majority to proceed on the bill, which as a result was referred back to the VA Committee.

AAMFT members wishing to support increasing funding for the Minority Fellowship Program may visit **http://www.congressweb.com/aamft/7.**

Medicare MFT Legislation: Good News, Bad News

IN THE PREVIOUS *FTM*, we noted that in December, Sen. Wyden (D-OR), the chief sponsor of a bill (S 562) that would add private practice MFTs (and LPCs) to Medicare eligibility, had filed this bill as one of 137 amendments proposed for action by Senate Finance (Medicare) Committee members for a Medicare "Doc Fix" bill, but that Sen. Wyden did not request that this amendment be actively considered in that process. This was a sign that Medicare MFT coverage is important to Sen. Wyden, but not his top priority.

Since that time, there has been good and bad news for Medicare MFT coverage. In good news, the prior Finance Committee chairman, Sen. Baucus (D-MT), resigned from Congress to become Ambassador to China, and Sen. Wyden is the new chairman. This is very good news because the chairman controls the committee's agenda. **In addition, on February 4, the 37 million member AARP (formerly the American Association of Retired Persons) endorsed Medicare MFT coverage for the first time.**

The bad news is that neither the full Senate nor the House of Representatives had acted on their respective versions of a Medicare "Doc Fix" bill. So there had been no opportunity to consider adding Medicare MFT coverage as an amendment on the floor of either Chamber. And because Medicare MFT coverage has a cost, it would be very challenging to add as a floor amendment; the Doc Fix bill already has a 10-year cost estimated at $150 billion.

As of March 31, the Senate voted to pass the bill approved by the House, the 17th time Congress has acted since 2003 to temporarily delay cuts to doctor reimbursements under Medicare. But lawmakers could not summon the votes to permanently fix the problem, which is caused by the formula used to determine funding levels for Medicare that repeatedly causes a shortfall. Although a permanent replacement is preferable in the long term, a patch offers another opportunity to add Medicare MFT coverage at a later date.

AAMFT members wishing to support increasing funding for the Minority Fellowship Program may visit **http://www.congressweb.com/aamft/6.**

New Health Reform Plans Roll Out Amid Challenges and Provider Uncertainties

The new Exchange (also called Marketplace) health plans for uninsured middle-income Americans has been in place for two months. Mass media reports have ranged from jubilation by newly insured people to horror stories of administrative hurdles for both enrollees and healthcare practitioners. For practitioners, the two main problems seem to be uncertainty about whether a provider is or is not contracted with specific Exchange health plans (which has a major bearing on those plans' pay rates) and, where a provider clearly is contracted, the plans' resulting payment rates, which anecdotally are low.

Members having good or bad experiences with these plans are requested to report details to **advocacy@aamft.org.**

advocacy update

Division Advocacy

This table provides a very brief description of the AAMFT division advocacy agenda items for 2014. This table is based on information provided by division leaders to AAMFT. Agendas may change during the course of the year due to unexpected opportunities to pursue a long-term agenda item, or to an unexpected challenge to the profession.

Division Name	Initiatives
Alabama	No advocacy report filed
Alaska	Medicaid and regulatory fees
Alberta	Regulation
Arkansas	Continuing education
Arizona	Licensure regulations
British Columbia	Regulation
California	Licensure Board and MFTs in clinics
Colorado	No advocacy report filed
Connecticut	Associate licensure and Medicaid
Florida	MFTs in the schools and amendments to licensure law
Georgia	Scope of practice and amendment to licensure law
Hawaii	Continuing education
Idaho	No legislative agenda reported
Illinois	MFTs in the schools
Indiana	Sunset review
Iowa	Medicaid
Kansas	Scope of practice
Kentucky	Continuing education
Louisiana	Scope of practice and associate licensure
Maine	No legislative agenda reported
Manitoba	Regulation
Massachusetts	Private payer reimbursement
Michigan	BCBS recognition and scope of practice
Mid-Atlantic	Amendments to licensure law
Minnesota	Medicaid and MFTs in the schools
Mississippi	Scope of practice

Division Name	Initiatives
Missouri	Medicaid and vendorship
Montana	No legislative agenda reported
Nebraska	State ethics code amendments
Nevada	Licensure regulations
New Hampshire	No legislative agenda reported
New Jersey	Licensure regulations
New Mexico	Continuing education
New York	Scope of practice and vendorship
North Carolina	Private payer reimbursement and Medicaid
North Dakota	Medicaid and BCBS recognition
Ohio	MFT trainee recognition
Oklahoma	BCBS recognition
Ontario	Regulation
Oregon	Private payer reimbursement
Pennsylvania	Practice protection and Medicaid
Quebec	Private payer reimbursement
Rhode Island	No legislative agenda reported
Saskatchewan	No agenda reported
South Carolina	MFTs in the schools
South Dakota	Medicaid
Tennessee	MFTs in the schools and distance therapy
Texas	Sunset review
Utah	Associate licensure
Virginia	Licensure board
Washington	State job classification
West Virginia	No legislative agenda reported
Wisconsin	MFTs in the schools
Wyoming	Medicaid

Wyoming

The Wyoming Division of AAMFT was successful in its efforts to pass a bill into law that will allow MFTs in private practice to be recognized as independent providers of services to Medicaid enrollees. LMFTs, counselors and social workers in private practice have been able to provide services to Medicaid recipients only if covered services to these recipients were provided under the direction of a physician. To correct this problem, the Wyoming Division and organizations representing counselors and social workers supported legislation that would eliminate this unnecessary and burdensome supervision requirement, and allow MFTs and the other providers in private practice to be recognized as independent providers by Medicaid.

Introduced on February 11, this legislation passed the Wyoming House on February 24 and the Senate on March 4. On March 10, Governor Matthew Mead signed this bill into law. Congratulations to the division on this important accomplishment, which is due to the advocacy efforts and hard work of the division's leaders, members and allies. During this process, AAMFT provided information and assistance to the division, including sending a letter of support to a key legislative chair.

Ethics Report

Members of the AAMFT in all membership categories, AAMFT Approved Supervisors, and applicants for membership and the Approved Supervisor designation are bound by the AAMFT Code of Ethics. Allegations of code violations are investigated by the Ethics Committee according to the AAMFT Procedures for Handling Ethical Matters. Members found in violation may appeal the Ethics Committee's findings and recommended actions to the Judicial Committee. The possible outcomes of an ethics complaint include: a finding of no violation; finding a violation and recommending a mutual agreement with the member (e.g., supervision, education, therapy, community service, suspension of membership and/or the Approved Supervisor designation); or termination of AAMFT membership. Termination is a permanent bar to readmission. In general, only terminations are published.

- Effective December 6, 2013, the membership of David H. Ridley, a resident of Idaho Falls, Idaho, was terminated with a permanent bar to readmission to the Association for violating Subprinciple 3.15(e) of the AAMFT Code of Ethics.

The current AAMFT Code of Ethics is available online at: http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx. The Ethics Committee can be reached at ethics@aamft.org.

feedback>>

I just received the *Family Therapy* magazine on Spirituality and Faith. Thank you very much for publishing this. Not only will this help MFTs think about how to better work with any religiously oriented clients, but such discussions and topics will help religiously oriented MFTs feel connected and a part of AAMFT.

Thank you for doing this. But most of all, thank you for listening.

Warm regards,
Ben
Benjamin Erwin, PhD, LMFT
UAMFT President
Argosy University

What You Need to Know About the Challenges of MFT Full Licensure

THE SUPERVISEES' PERSPECTIVE

Kim McBride, MA **Lisa Hunter, MA** **Laura Heck, MA**

You have completed your graduate program and the celebrating is behind you. In front of you, however, is the challenge of becoming a fully licensed marriage and family therapist. When reality sets in, you realize that you are only half way up the mountain, and the path for the second segment of the ascent isn't as clearly defined as the first. You know you have all the necessary equipment in your backpack, except for that detailed map you had for the first half of your journey.

For the purposes of this article, we will refer to the "Associate" stage of becoming a fully licensed marriage and family therapist, though your state may call it an "intern," "registered intern," etc. The Associate stage can be confusing, and at times, discouraging. You begin to ask yourself, "How do I start to pay off my student loans and still earn a living as a therapist? How do I retain clients when I'm not credentialed with insurance panels? What's the best way to go about studying for the MFT exam? What makes a great supervisor, and how do I find one who will work well for me and who I can afford?" These are questions we asked ourselves during our journey, and we want to share what we discovered in the hope that our suggestions will lessen some of the obstacles in your path. **Here are our six big takeaways:**

1. Be Financially Creative

When your student loan payments are due, the pressure is on to find a paying clinical position. Competition is high, even for part-time jobs. It can be difficult to earn a substantial living during the associate phase of licensure. The pay is proportionally out of balance compared to the time you have spent in school. If making ends meet as a therapist is an issue for you during this time, consider stepping somewhat outside the mental health world. It may be helpful to keep one foot in your previous career and one foot in the mental health world: hopefully forming two viable part-time jobs. Or, it may be necessary to maintain a full-time job (that may or may not be related to the mental health profession), while meeting with clients in the evening or on weekends in order to accumulate direct client contact hours towards licensure.

2. Buddy Up for Supervision

We cannot say enough about the benefit of having a partner throughout the supervision process. First of all, it is helpful to have peer support—someone you can call to debrief about a challenging client, ask for thoughts about a case, to celebrate a therapeutic win, or to commiserate a temporary defeat. Secondly, when in a supervision meeting, it's helpful to hear about other cases from others who are in the same place in their career. This gives you an opportunity to consider how you would manage this particular case, offer suggestions, and get on-the-spot, direct feedback from your supervisor about all of the aspects of the case. Splitting supervision with a buddy equates to half of the expense for you (big bonus, refer back to #1). And you may need that supervision buddy to help hold you accountable for attending routine supervision sessions.

3. Marketing Tips to Gain Direct Client Contact Hours

In actuality, there are not enough community mental health therapist positions for recent graduates, or perhaps working in this setting is not in your professional interest. You may consider private practice or working as an independent contractor in a private counseling center in order to accumulate direct client contact hours towards full licensure. The challenge is that associate level therapists are not eligible for paneling with insurance companies. Marketing yourself during this associate phase becomes paramount to reaching your goal of full licensure, as does finding clients who do not rely on insurance.

Here is what we learned about getting started. First, concentrate on your interests and strengths, and let others know about them. Find your own niche, so that when licensed therapists think of couples, for instance, or teenage girls, or infertility, your name comes to mind because that's what you identified as your area of focus. Be specific. Consider building a website that highlights your areas of interest. Start a blog via this website featuring current therapy topics that are relevant to the type of client you want to attract. A blog is a great way to periodically remind followers about you and your areas of interest. Create a Facebook page for your business. Generate a Linkedin profile and connect with other professionals. Most social media is free to join, and it is an excellent way to let others know about you as a therapist.

Because you are also required to accumulate continuing education hours, choose classes or workshops specific to your area of focus. In some cases, attending trainings will get your name on publicized referral lists, which is a great way to attract clients in your area of interest. If you are interested in a particular training but cost is an issue, contact the organization conducting the training and ask if they are looking for volunteers. Often these organizations recruit volunteers to help in exchange for attending the training at a reduced rate. We have found that many clients have sought us out because of our areas of focus and these clients have been willing to pay full fees out of pocket to retain us.

You also might consider paying for some form of minimal advertising. Place a monthly ad on the Psychology Today therapist finder, which offers a direct link to your business website, where potential clients can learn more about your practice.

Third, consider hosting a free presentation at your local library or community center. Pick a topic relevant to your area of focus. Once people meet you in person and see how personable and passionate you are about your subject, they'll remember you for when they or someone close to them is in need of a marriage and family therapist.

Fourth, market yourself to fellow therapists (both associate level and fully licensed), local physicians, psychologists, psychiatrists, etc. Let them know the types of clients you prefer to work with and where they can find you, but don't just visit them once and be done with it. Plan to stay in touch via e-mail, snail mail, or in person to see if they need more of your business cards (which can usually be ordered online for a nominal charge). Remind them of your special interests and that you are a valuable resource for their client or patient base. Since your fees should be lower than fully licensed therapists, let these professionals know that you are a great option for their clients who are paying out of pocket. If you see clients on a sliding scale, let them know this as well.

> Supervision is an isomorphism for the client/therapist relationship, so choose your supervisor as carefully as your clients will choose you.

A note about session fees: Be flexible. Consider reserving a few slots for clients who need a reduced sliding scale fee. Since you will be ineligible for insurance paneling during this time, consider seeing some clients for the equivalent of their insurance co-pays. Decide in advance how many of these reduced-fee clients you can afford to take, and stick to it. Know your financial boundaries. Unless you are in a community mental health setting, it is a constant balancing act between getting enough clients to accumulate the required number of hours for licensure and generating income.

4. Pool Resources for the AMFTRB National MFT Exam

In our opinion, joining a study group does not necessarily work for everyone; however, meeting in a group setting to discuss strategies and exchange materials can be highly productive. There is an abundance of preparation packets, books, smart phone applications, websites, worksheets, etc., to help prepare for the exam. Connect with someone who recently took the exam and ask them on which materials they would recommend you concentrate. We recommend taking the AMFTRB practice exam early on in your studying versus waiting until the end. This gives you a gauge as to your areas of strength and highlights those areas that might require further concentration.

Use supervision as an opportunity to prepare for the exam. Before choosing a supervisor, ask any potential candidates how they can help you in preparing for the exam. Our supervisor provided a detailed study program that was extremely helpful. She put together a program that included a review of helpful study techniques, review of theory, case vignettes and ideas to manage exam anxiety.

5. Select an Excellent Supervisor

What makes an excellent supervisor? Aside from the AAMFT Approved Supervisor requirements and required theoretical

knowledge, a great supervisor supports you and helps you reflect on how and why you got to where you are, and, more importantly, encourages you to envision where you see yourself in the future. To some extent, this person should be a reflection of how you view yourself: someone who is professional, responsive, committed, supportive, and empathetic to his or her supervisees, just as you are with your own clients. It is helpful if your supervisor aligns with your therapy theory of choice. Supervision is an isomorphism for the client/therapist relationship, so choose your supervisor as carefully as your clients will choose you. Interview a few potential supervisors with your supervision partner, and then choose the one you envision yourself with for the duration.

6. Make Intentional Choices

In closing, remember to be intentional while in your associate phase. Select a clinical position that is in your preferred area of interest. Do not become desperate or deterred from your goal. For example, if you really want to work with children with autism but fall into a position working with military couples, move on. The choices you make now will have a ripple effect on your future career.

Be flexible and creative in order to accommodate both your professional and personal needs during this time. Ask for support from your supervision buddy or supervisor, as needed. Enjoy what you do and continue to climb the mountain, being mindful of the current terrain while keeping an eye on the peak. Envision how you want to experience yourself once you've completed this final ascent towards full MFT licensure, and take the path that's right for you in order to get there.

The Supervisor's Perspective

Now, more than ever, associate level MFTs report the need to complete the licensing process in an expeditious and affordable manner. Because the majority of recent associates completed their graduate training during the latest financial collapse, many incurred multiple high interest student loans to earn their degrees. In their quest to become licensed therapists, they typically choose one of two paths: 1) to work in non-profit community mental health agencies; or 2) to work in for-profit private practices.

The non-profit path is replete with clinical and professional training, consistent client hours, and complimentary supervision, thus affording associates a predictable two-year licensing process. The disadvantage of community agency work as a path to full licensure is meager wages and benefits. The private practice route often involves taking on a second job to off-set the cost of the clinical/professional trainings required for full licensure, and typically requires more than two post-graduate years to attain the required clinical experience and supervision hours. In addition to the extended post-graduate licensing period, associates who choose the for-profit path face several challenges: a) finding affordable supervision that develops clinical and professional competence while preparing the associate to pass the AMFTRB examination; and b) sustaining momentum through the protracted licensing period.

The following are suggested strategies for a supervisor to engage and retain the interest and motivation of supervisees during the post-graduate licensure process.

Providing Cost Effective Supervision. Supervisors have significant legal, ethical, and clinical responsibilities to evaluate the competence of associates for full licensure, and to set their fees for supervision accordingly. That said, associates cite supervision fees as an important factor when selecting a clinical supervisor and continuing ongoing supervision. To offer affordable supervision that generates acceptable income, supervisors may look to:

1. Offering multiple configurations of supervision, i.e., individual and group supervision, allowing associates to move between the two options as their finances dictate (group configuration is typically a lower fee than individual supervision). Such options tend to increase associate retention rates and the probability of completing full MFT licensing.

2. Establishing a set fee for services in place of a sliding fee scale in addition to a reduced rate for specific universities (i.e., your alma mater!), or community mental health agencies functioning on shoestring budgets that are unable to meet the demand for onsite direct supervision services. This way, supervisors provide much needed qualified and cost effective clinical services while marketing their services to educational institutions and community agencies that continuously generate newly licensed associates who require supervision services.

Providing Competency-based Clinical Supervision. The primary responsibilities of a supervisor are to evaluate the clinical and professional competence of associates for clinical practice, to protect client welfare, to prepare associates to pass the AMFTRB examination, and to advance the MFT profession. The following recommendations serve to develop clinical, professional and ethical competence, while simultaneously preparing associates to pass the AMFTRB examination:

1. Provide a balance of supervision methods and techniques, including case consultation, written and oral self-report, and live data, i.e., audio and video encrypted session recordings, live observation, co-therapy, skill demonstrations, and role playing.

2. Emphasize engagement in live supervision. Research shows that associates who participate in even one live supervision session over multiple client sessions report "significant" therapeutic progress (Silverthorn, Bartle-Haring, Meyer, & Toviessi, 2009).

3. Teach tailored skills in conjunction with theory. Provide a balance of the conceptual and clinical skills necessary for associates to effectively respond to clients' intrapersonal and sociocultural needs (Anderson, Schlossberg, & Rigazio-DiGilio, 2000).

The Protracted Licensing Period

From the time of initial application, most states set a maximum number years to complete post-graduate supervision and clinical hours (i.e., Washington State allows a maximum of five years as a family therapist associate). While many associates make use of the protracted licensing period, sustaining motivation over that amount of time can be a challenge. The following aspects of supervision keep supervisees coming back for more:

- Warmth and openness
- Expertise
- Trustworthiness
- Providing clear and direct feedback
- Tailoring supervision to the unique needs of associates
- Offering a variety of supervision formats, structures, methods and techniques

Supervisees who connect with supervisors possessing the above-mentioned attributes will: a) view clinical mistakes as opportunities to learn; b) provide supervisors clear and direct feedback; c) view cultural differences in the supervisory relationship as respected and valuable topics of discussion; and d) readily explore new clinical skills and theoretical frames while developing their theoretical approach to therapy (Hildebrandt, 2009).

Additional Engagement Strategies:

1. Require associates to participate in peer/group supervision at least once a month, in conjunction with individual supervision. In doing so, associates obtain ongoing peer support, clinical feedback, networking opportunities, and exposure to diverse theoretical perspectives, all of which increase the associate's engagement in supervision and connection to vital collegial support.
2. Require each associate to provide one brief article review from current professional literature. The article review should be assigned on a rotating basis and presented during peer supervision—one presentation per group supervision session (Hildebrandt, 2009; Anderson, Schlossberg, & Rigazio-DiGilio, 2000).
3. Organize and participate with associates in yearly onsite clinical trainings.

The professional road to full licensure is long, the challenges many, and the rewards immense. However, professional development does not end with the attainment of full licensure. Supervisors should encourage fully licensed associates to continue their professional development by becoming state level and AAMFT Approved Supervisors, Supervisor Mentors, and/or Family Therapy Educators. In doing so, marriage and family therapists will continue to advance the profession.

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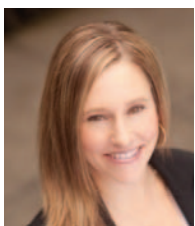

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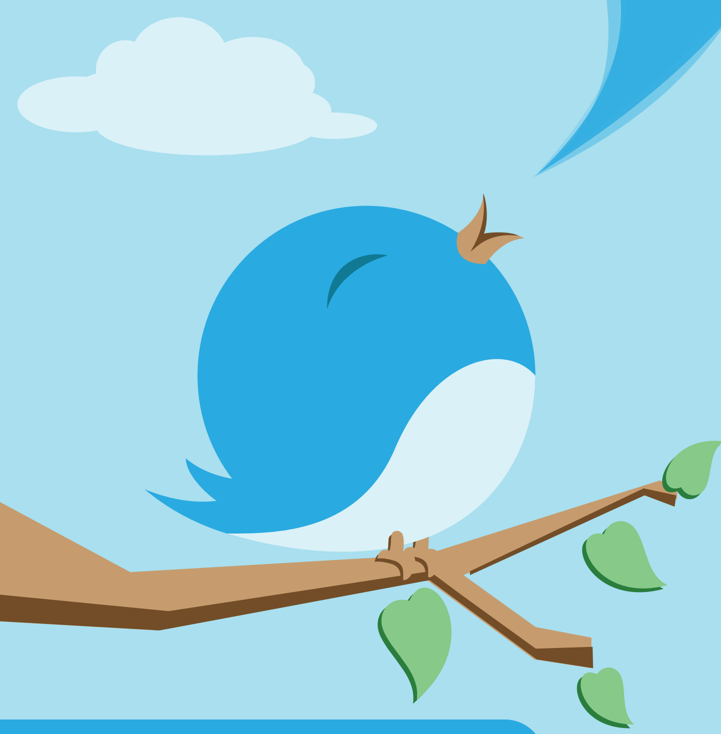
Twitter Chats

First Wednesday of each month
3:00 p.m. Eastern
@TToddMFT



May: Facebook "Question of the Week" submissions for TToddMFT

June: Systemic Treatment/ Why become an MFT?

July: Leadership (follow-up to ASAE Canada event)

August: Advocacy issues

September: TBD

October: Solution-focused Therapy

November: Feedback on AAMFT14

December: TBD

To follow and/or participate in the Twitter Chat, follow Tracy Todd on Twitter @TToddMFT (www.twitter.com/TToddMFT) and include #AAMFT_Chat in your tweets.

Participation in the chats will require access to Twitter and a Twitter account, however you do not need a Twitter account to follow along.

To follow AAMFT Executive Director Tracy Todd's messages/tweets, visit www.twitter.com/TToddMFT.

Diversity
IN TODAY'S FAMILIES

The year 2014 marks the 20th anniversary of The International Year of The Family, and the occasion has been taken up around the world as an opportunity to focus on families in order to recognize how far we've come, and what is yet to be achieved.

Family Therapy magazine invited faculty at Guelph University in Ontario, Canada to share some views and thoughts on families today in North America. As part of a dedicated group, the authors recently prepared for an annual conference (The 36th Annual Guelph Sexuality Conference) attended by a wide range of disciplines, including mental health professionals, making it an exciting challenge, and opportunity, to consider the Year of the Family. The conference planning sessions led the group to ask tough questions and make important decisions about how families should be discussed, portrayed, and perceived. Many of those questions are important for all of us to ponder and take into consideration in our own practices or agencies, as well as in our personal lives.

The process of working on a conference dedicated to family led us to consider many important issues relational therapists and researchers must face each day. In Canada, the family has been recognized as central to the fabric of society since its inception. Part of Canada's dedication to family is an effort to recognize ways in which to support a plethora of strong relationships. Maternity leave benefits (now up to 52 weeks, paid) came into being almost 50 years ago. Gay marriage was recognized in 2005, making Canada the fourth country in the world to legalize same-sex marriage. But families everywhere still face challenges as we continue to strive to match our policies and social expectations to the realities of diverse and evolving definitions of family.

How does one define "family"? Is it by a recognized structure, shared residence, time invested, shared resources, or blood and legal ties? Each of these presents unique challenges, leaving out large numbers of people who identify themselves as family members. We often turn to the definition offered by The Vanier Institute of the Family in Ontario (2014). According to their definition, family is defined by a combination of form and functions. By this understanding, a family is:

...any combination of two or more persons who are bound together over time by ties of mutual consent, birth and/or adoption or placement and who, together, assume responsibilities for variant combinations of some of the following:

- Physical maintenance and care of group members
- Addition of new members through procreation or adoption
- Socialization of children
- Social control of members
- Production, consumption, distribution of goods and services
- Affective nurturance—love

While this definition of family has helped to guide us in many ways, it is important to remember that it is not up to outside parties to define any relationship structure. Families define themselves. Those who strive to qualify what counts as a family are sadly misled.

For family therapists, these questions around the definition and structure of families are constant, so much so that we often cease to realize it. From determinations around which training clients count as the all important "relational hours," to the construction of intake forms and even the decor of our practice spaces. Who are we welcoming and who is ignored in our personal and professional definitions of family? Would you include my family, and would I extend the same consideration to yours? Can your potential clients tell if they are respected as a family by your first impressions?

"It is important to remember that it is not up to outside parties to define any relationship structure. Families define themselves."

Family researchers face similar conundrums. In our research, designing questions that assess gender, sexual orientation, and relationship status and duration poses a challenge, given the vast diversity of ways individuals and partners identify. As researchers, the way we develop quantitative surveys communicates a great deal about our personal and cultural biases. The response choices we offer in such studies indicate how accepting we are of the participants' ways of living and being in relationships.

The same is true of a therapist's intake forms, which often dictate limited options for gender, sexuality, and relationship or family structures. When interviewing participants, researchers' prompts, and verbal and non-verbal reactions, can at once help participants to feel valued and understood or excluded and invisible. Our clients encounter similar cues from our first conversations through the termination of services. Across professions, we make a statement about our values with every word we choose when describing our participants, findings, hypotheses, or clinical approaches. Those in a position of power, such as therapists and researchers, have a duty and obligation to utilize our privilege in the service of broadly defined diversity. The more power we hold, the more we must hold ourselves accountable.

We kept these concerns at the forefront when planning our conference. As one might suspect, coming up with the right balance for combining sexuality and family led to many interesting conversations in our planning group. But the best conversations came from the simplest question: what is "family" and how can we embrace all of the possible answers to that question? Suddenly these significant questions faced by therapists and other professionals around the globe had become immediate, and our answers needed to be progressive, respectful, and concrete.

Approaching the task felt much like basic business planning for a new family therapy private practice or agency. Embracing the diversity of forms families can take was critical to our planning committee. And that began with selecting the theme and image for the event. The challenge began with selecting a graphic for our promotional materials. How could we welcome all families with a single image? Would street youth see themselves in an image with apartments and housing? Do these images of humans reflect gender diversity beyond male and female, and can we back that up with a dedication to offering multi-gender restrooms in this year's space? Children enter (and exit) families in a wide range of ways, or not at all. Should children be present in the image? What about leather families, drag families, poly structures, and other families of choice? Who are we forgetting?

As any therapist who has struggled with these practical considerations might guess, hours of searching revealed no images of people that reflected differences in sex, gender, age, body, and relationship configuration. Even symbols of family, like the home and the heart, were rejected because of their class and ethno-cultural meanings. We landed on images of fireworks, visually appealing, but not value-laden. To us, they represented the celebration of diverse families we hoped would take place at the conference.

The theme, Celebrating Family Diversity: Action, Advocacy and Affirmation, worked for us because it simultaneously communicated (we hope!) the excitement we feel about families broadly defined and diverse, but also recognized the work that is required in the form of action and advocacy, to continue to defend the rights of all to define their families and access supports. Striking a balance with the theme, between recognizing how far we have come, related to sexuality and relationships, while also acknowledging the work to be done, has always been of high importance for this event.

In what ways do we celebrate the diversity of family through action, advocacy, and affirmation in our practices, marketing, and paperwork right down to decorations in our offices? How do we continue to expand our understanding and competencies around newly recognized concepts of family so as to better serve the relational contexts of our clients and communities? In this issue, we have the opportunity to broaden our horizons through the explorations of topics such as IVF, same-sex adoptive families, multiracial families, multi-partner/poly amorous families, and any combination of those types. This is an important initial step, but the journey has only begun.

Whether we work as therapists, researchers, teachers, or on a conference planning committee, we hold a great deal of professional power and privilege. With these come unique opportunities to create systemic change to the benefit of all families, especially those who are underrepresented within our field and power structures. Creating change in such ways often requires a dedication to rejecting hegemonic forces that endorse inequality and tightly controlled resources, reserving these benefits for those who already carry the most influence. Feminist and author bell hooks (who does not capitalize her name) (1996) has aptly stated that, when comparing oppressed with privileged groups, "One group can change their lot only by changing the system; the other hopes to be rewarded within the system." When we find ourselves with undue privilege, it is our duty to use it to create change in the distributions of power instead of seeking to reinforce existing systems based on inequality and imbalance. Like many of the most important historical shifts, this begins with the family. But this time, it is through the recognition of how beautifully complex and endlessly immense "family" is. It is our job to reflect this in our work, whether we are planning conferences or working with client families.

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Dana Stone, PhD

WORKING WITH MULTIRACIAL INDIVIDUALS AND FAMILIES:

Increasing our Understanding

The Intersection of Multicultural Awareness and Clinical Practice

As ethical practitioners of marriage and family therapy, we must integrate multicultural awareness and sensitivity into our clinical practice. However, as practitioners in the field, there may be a struggle to intersect what we have learned in graduate school and effectively addressing issues of culture and race into our daily practice. When we are students, we are made more aware of our own multicultural context, as well as the multicultural context of most of our clients. However, as we get deeper into our clinical careers and farther away from school, we may lose sight of the critical importance of openly addressing the myriad racial and ethnic issues our clients may bring to therapy.

The Multiracial Population

The 2000 U. S. Census was the first time in history multiracial individuals were able to mark more than one racial category and approximately 2% or 6.8 million of the United States population selected more than one race (Armas, 2001). In 2010, individuals selecting two or more races on the Census accounted for 2.9% of the total population or 9 million people; approximately a 30% increase since the 2000 Census (Saulny, 2011). From the 2010 Census data, we know that approximately 42% of those reporting more than one race were under the age of 18, implicating these individuals as the fastest growing minority group among American youth (Killian, 2013; Saulny, 2011). This means an MFT working with one or more of these individuals or families in their clinical practice is highly likely. While the concept of multiracial individuals and families is not new, the continued population growth of these individuals and families reminds MFTs of the unique resiliencies, struggles, and possible challenges to be mindful of when working in therapy.

What Struggles?

As an MFT, you may ask yourself, why do we need a special focus or understanding of multiracial individuals and families? This is because there still exist racial borders and divisions in the United States, inevitably affecting the experience of the couples who partner with someone outside their race and the children they may produce as a product of their union (Killian, 2013). Exploring race and the term multiracial is complex, and while it does not capture the language or experience of all interracial or interethnic families and children, multiracial will be used for the duration of this article to describe those youth and families who have any multiple race or multiple ethnic heritages. While today there is an overall increase in acceptance of multiracial unions and families and more support for multiracial individual's choice in selecting more than one racial category on the U.S. Census, there is still social intolerance and lack of acceptance and understanding across many groups in the US for interracial marriage and multiracial children (Killian, 2013). And while therapists are cautioned not to assume that just because a multiracial individual or family comes into therapy that their problems are centered in their multiracial experience, we know we cannot ignore the impact of living in a racially stratified society for these groups (Laszloffy, 2008).

These families and individuals may struggle with the process of communicating about and exploring racial identity options within their immediate and extended family (Lazsloffy, 2008); they may experience lack of acceptance or support with extended family (Childs, 2005; Nadal, Sriken, Davidoff, Wong, & McLean, 2013); they may face negative and stigmatizing reactions from strangers including microaggressions and prejudice (Bratter & King, 2008; Nadal et al., 2013); they may experience the personal, familial, social, and/or political pressure to identify with or to deny one of their racial heritages; and they may experience rejection or lack of support from social groups including neighbors, peers, teachers, and communities (Rockquemore & Lazslofffy, 2005). All of these factors may contribute to or exacerbate the individual's or family's presenting issues in therapy.

Possible Clinical Issues

Identity Development

When multiracial children are developing their sense of identity, including their sense of what it means to be a multiracial being, they compare themselves to those closest to them, usually parents and siblings first (McClurg, 2004). Naturally, a multiracial child may not find siblings or parents who look like them. This can present challenges for the child seeking sameness with those closest to him or her and difficulty for the parent, who may not know how to help the child navigate this unique process of multiracial/multiethnic identity development. Additionally, monoracial parents may not realize the importance of communication about race and their child's unique multiracial heritage. One possible outcome for the child is a feeling of isolation or "otherness" in the family.

Microaggressions in the Family

Racial microaggressions are defined by Sue et al. (2007) as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward people of color (p. 271). While multiracial individuals experience these microaggressions the same as their minority monoracial counterparts, what has more recently come to the forefront is the unique experience of multiracial individuals encountering microaggressions within their own families, in addition to those suffered in other social settings in their lives (Nadal et al., 2013). Within the family, as children move in and out of extended family networks, they may experience "not fitting in" with extended monoracial family members. This can happen with family members discounting the chosen multiracial identity of the child or favoring one monoracial identity over another (Nadal et al., 2013). Also, some multiracial individuals experience being intentionally left out of extended family events and occasions due to the extended family's disapproval of their multiracial family and identity. Such experiences mean lack of support for the multiracial family unit, more feelings of isolation for the individual, and a sense of distance from the extended family.

Social Microaggressions, Racism, and Prejudice

Microagressions, racism, and prejudice against multiracial children happen in schools and communities, with teachers, peers, and even with friends (Laszloffy, 2008). In social settings multiracial individuals may be dismissed or excluded from belonging to either of their racial heritage groups, leaving them left out or isolated in social situations. Such exclusion can contribute to the negative well-being of multiracial individuals growing up. Another experience many multiracial individuals face may be rejection or criticism of their racial identity choice or racist or negative remarks about one or more of their racial or ethnic heritages (Rockquemore & Laszloffy, 2005). This can occur overtly in situations such as being forced to choose or reject one racial identity in peer groups, the classroom, and in social groups. It can also occur when racist or prejudiced remarks are made in social situations in which the mixed racial heritage of the multiracial individual is unknown. Such experiences can cause suffering and distress for the multiracial individual because they cannot find support from either heritage group and

> Forming a family identity as an interracial unit, in the family's own terms, can signify coming together at all times

could lead to a low sense of self worth and possible depressed mood (Townsend, Markus, & Bergsieker, 2009).

Helping Families Overcome

Inviting conversations about topics related to family and the multiracial experience early in therapy will enable clients to clarify with the therapist whether or not their problems are centered in racial issues. Involving family in therapy is most useful when working with multiracial youth who may be struggling with issues related to their multiracial experience. When working with multiracial individuals and interracial families in therapy, safety and openness between the client family and the therapist is critical in order for intimate conversations about race and racial identity to take place.

Psychoeducation and Facilitating Open Communication

Numerous researchers have revealed that a supportive family environment and strong parent-child relationships contribute to a positive and healthy multiracial identity development process (Rockquemore & Laszloffy, 2005; Stone, 2009). Thus, when working with multiracial individuals in a clinical context, interventions that involve the entire family are most helpful (Kenney, 2002; McClurg, 2004). First and foremost, clinicians may need to offer family members psychoeducation on possible racial loyalty binds, about healthy identity development and/or multiracial identity development and self-concept; the importance of acknowledging the differences between the parent(s) and child's racial identity and racial experiences in the world, and encouraging open discussions about racial heritage (Hud-Aleem & Countryman, 2008; Laszloffy, 2008).

For therapists to approach issues such as managing differences or tension between both sides of the family or the multiracial individual not having parental support or parental understanding of experiences associated with the multiracial identity development process, it has been suggested by Kenney (2002) and others that therapists encourage interracial parents to talk about their own racial heritage as well as to acknowledge that their child's racial heritage is different than their own. In addition, when working toward a better understanding between parents and their multiracial children, forming a family identity as an interracial unit, in the family's own terms, can signify coming together at all times, and especially during times of difficulty and challenge. Coming together as a family unit and establishing open communication and a shared belief system about race and multiracial heritage allows families to succeed together in the face of family of origin and parent-child conflict as well as to deal better with hardships in the world outside the family.

Cultural Genograms

It is also crucial to explore during therapy the impact of and interaction with multiple family members including: parents, step family members, siblings, grandparents, and great-grandparents which can be accomplished with the use of genograms to increase understanding of multigenerational family relationships, dynamics, communication, and rules. A culturally focused genogram can also help the multiracial individual and the family to explore their multiracial heritage across generations, as well as to explore the values and beliefs of the parents who are raising the multiracial children and extended family members regarding racism, microaggressions, race, and multiracial identity.

Social Supports

Therapists should also consider the impact of the social and historical context within which the family and individual live. Assessment questions with interracial families and multiracial individuals might explore what it has meant to the multiracial individual to grow up with a unique racial heritage and who in his or her life and community is sought for support. Such contextual supports can be identified with the use of an ecomap, visually representing the circles of support for the individual and family. Researchers have found that exploring the individual's and family's relationships with social networks, community, neighborhoods, and other institutions can increase the understanding of acceptance or lack thereof. Oftentimes it is up to the multiracial individual and family to educate others in their communities about their experiences and doing it together as a family can alleviate the pressure and reinforce family resilience. Additionally, the importance of community supports and social networks cannot be underscored enough, since researchers have found they contribute to positive psychological outcomes for the multiracial children and their families.

The multiracial experience is complex and this article serves to highlight only some of the multiracial person's experience. The goal of this article was to emphasize the growing number of multiracial individuals and the unique experiences of multiracial individuals and their families. As with any other family seeking help from an MFT, multiracial families share similar reasons for attending therapy (Laszloffy, 2008), however, there are unique dilemmas these families and, most

especially, multiracial youth may face. As multiculturally aware practitioners serving families, it is important to be prepared to explore these complexities in therapy with some confidence.

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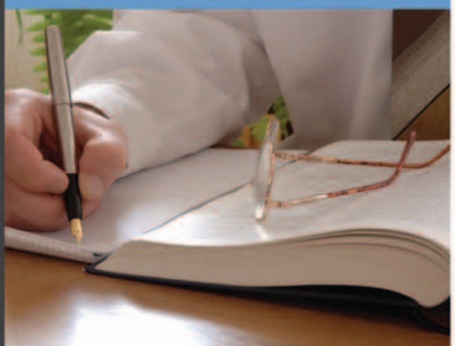

Considering Monogamous Privilege

Markie L. C. Blumer, PhD

Coreen Haym, MS

Kevin Zimmerman, PhD

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This may come as a surprise—in the last U.S. presidential election (2012), both of the major party candidates came from polygamous cultural backgrounds. Mitt Romney's paternal great grandfathers moved to Mexico to practice plural marriage, as it had been outlawed in the U.S. in 1862, and President Obama's father belonged to the polygamous Luo tribe of Kenya. It is incredible that both candidates were descended from recent polygamous ancestors when no other presidential candidate in history had been before—a truly remarkable instance of diversity within the U.S. (Maraniss, 2012).

Closer to home, I (Blumer) recently attended my first multiple-partnered commitment ceremony. It was an honor to have the opportunity to recognize the love shared between multi-partnered consenting adults surrounded by supportive family and friends. As I was preparing to attend the ceremony, however, I realized that I had no idea what kind of gift to get them, as they do not all live within the same home. Additionally, as I searched for a card, I quickly realized there were none available to commemorate this special occasion.

Each of these examples speak to a larger issue, which Haym, Blumer and Prouty (2013) presented at the AAMFT annual conference, and of which our co-author, Zimmerman, has been writing and presenting on for a number of years (2012). The issue is **monogamous privilege**, and the related concepts of **relational orientation,** and **mononormativity.**

To our knowledge, the concept of monogamous privilege has not yet appeared in the peer-reviewed literature, although privilege studies continue to expand. One of the earliest mentions of class privilege, for example, comes from a 1966 study (Woodward) of commerce in Guatemala. Then, in the late 1980s, the concept of heterosexual privilege (Frank, 1987) made an appearance, followed by McIntosh's (1988) groundbreaking article on White privilege and later male privilege (McIntosh, 1989). Other forms of privilege have received attention as well, including Christian privilege (Hackman, Peters, & Zúñiga, 2000), cisgender privilege (Bender-Baird, 2008), and able-bodied privilege (Kafer, 2003).

Monogamous privilege is defined as those unearned benefits afforded those with a monogamous and/or mono-partnered relational orientation, which also defines the relational orientation norm. In our experience, when we have shared the descriptor "relational orientation," people, particularly those in the U.S., seem almost immediately to become curious about etiology (Caldwell, 2013). At this point, experts in the fields of biology, archeology, and anthropology cannot agree with any certainty if relational orientation—whether it is of a monogamous, polyamorous, or polygamous type—is innate or choice-based (Engber, 2012). In any event, we believe as family therapists that it is our responsibility to be respectful of our client's relational orientation regardless of the form it takes.

The dominant relational orientation in practice in the U.S. is monogamous and mono-partnerships. However, researchers have recently found that approximately 4-5% of people identify as consensually non-monogamous (e.g., swingers, polyamorous, etc.) (Conley, Moors, Matsick, & Ziegler, 2012). The number of polygamous-identifying folks, although hard to determine, is estimated to be between 30,000 to 100,000 people, with the highest concentrations of polygamous families believed to be in the states of Utah, Idaho, Arizona, Texas, Nevada, Colorado (Jankowiak, 2008), and Pennsylvania (Hagerty, 2008). Looking at relationships more globally, in over 850 societies in the regions of Africa, Asia, Oceania, the Middle East, and the Americas, people practice polygamy (either polyandry or polygyny). Within some of these regions, up to 50% of the marriages are multi-partnered in nature (Al-Krenawi & Graham, 2006). Since monogamy and mono-partnered relationships are the numeric majority in the U.S., people identifying outside of this relational orientation can be thought of as relational orientation minorities (e.g., polyamorous, polygamous, swingers, etc.); defined as a person or people whose relationship orientation is identified outside of that of the dominant relationship orientation majority (e.g. monogamous, mono-partnered, etc.) (Haym, Blumer, & Prouty, 2013).

Monogamous privilege and relatedly mononormativity, defined as the dominant assumptions of normalcy and naturalness of monogamy (Barker & Langdridge, 2010; Pieper & Bauer, 2005), make it so that people and institutions construct walls of invisibility around individuals and multi-partnered relationships identifying outside of the dominant relational orientation. A consequence of this invisibility is that it forces relational orientation minorities to engage in ongoing visibility management (e.g., secrecy around and hiding of their relational orientation and relationship status, isolation of individuals and families, etc.).

The effects of invisibility management for relational orientation minorities in the U.S., particularly the legalities around multi-partnered relationships, are widespread. For instance, the illegality of plural marriage affects women's and families' access to permission to emigrate, and the secrecy that results from illegality can shape people's experiences during and after immigration. More specifically, illegality often leaves non-first wives susceptible to deportation. Polyamorous familial configurations lack legal support as well. Thus, interaction with the legal system for both kinds of multi-partnered configurations is often challenging and full of fear rather than relief. The potential for shame and secrecy and the threat of condemnation can defer individuals from calling police for help in instances of domestic violence, or in cases of child abuse, and can deter them from seeking legal aid. Parental rights and shared custody can be difficult to establish and prove when needed. Similarly, although there are instances of non-first wives or non-legally recognized partners attaining

"People and institutions construct walls of invisibility around individuals and multi-partnered relationships identifying outside of the dominant relational orientation."

alimony and access to a percentage of the family business upon marital or partner dissolution, this outcome remains rare and its rarity may be one of the many deterrents to multi-partnered relationships dissolving. Partners who are not legally married are also not covered under legal protection (e.g., communication and testimonial privileges).

Any one of these issues (in addition to those commonly experienced by anyone regardless of their relational orientation) might bring relational orientation minorities and their partners and/or family members into therapy, yet most family therapists have little to no awareness, knowledge, and related skills to access when working with multi-partnered configurations or identifying folks (Zimmerman, 2012). Additionally, personal bias surrounding consensually non-monogamous relations and multi-partnered relationships is rarely, if ever, approached in typical supervisory settings, educational studies of diversity (Zimmerman, 2012), and/or attended to in one's self-of-the-therapist considerations. Thus, it is simply left unaddressed until such time when a client(s) (or one of their ancestors, relatives, friends, or family members) presents as identifying outside of the dominant relational orientation.

Like working with clients of any diverse background, in order to remain ethical, viable and current so as to meet the relational and mental health needs of diverse populations, we have a responsibility as clinicians to work continually towards becoming more culturally informed. This includes becoming more competent in working with relational orientation minorities and members of their families. Becoming more culturally-informed with regard to any diverse population means starting with focusing on oneself, assessment of one's current level of competence, and working towards improvement (Aponte & Winter, 2000). Kim, Cartwright, Asay, and D'Andrea (2003) recommend focusing on one's cultural competence in relation to three interrelated components—awareness, knowledge, and skills.

As family therapists, we know that creating a space for growth, change, and healing within the therapeutic setting is always a baseline factor for any effective clinical work to take place. Consequently, it is necessary continuously to expand our knowledge and understanding of family and relational forms in order to increase competence. Simply challenging personal bias and assumptions related to the dominant relational orientation may seem like a small step in consciousness, and yet may make all the difference to the people presenting for help. Table A: Self-of-the-Therapist Questions around Minority Relational Orientations (page 33) presents a number of questions that therapists can ask themselves regarding their knowledge, values, and clinical insights related to relational orientation minorities. Ideally, clinicians will consider such questions and become more knowledgeable about non-monogamous and/or multi-partnered relationships before their first relational orientation minority client arrives in their office. In addition, we have included a number of resources that we have found helpful as therapists in raising our sensitivity to some of the unique concerns with which relational orientation minority clientele present.

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Additional Resources

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Table A: Self-of-the-Therapist Questions around Minority Relational Orientations

Knowledge

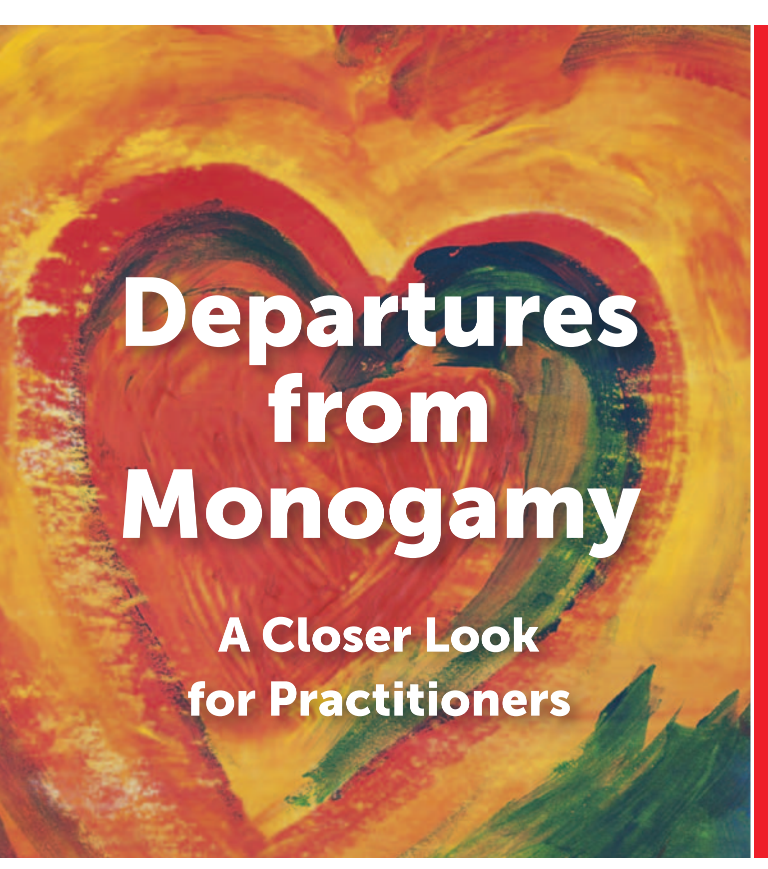
- What do I know about plural, polygamous, and polyamorous relationships and families?
- What are my experiences with plural, polygamous, and polyamorous relationships and families?
- Am I familiar with the language, terminology, etc. that is affiliated with plural, polygamous, and polyamorous relationships, families, and culture?
- What do I know about the different cultural (e.g., religious, secular, ethnic, sexual orientation, etc.) groups affiliated with plural, polygamous, and polyamorous relationships, and families?
- What do I know about the differences and similarities between plural, polygamy, polygyny, polyandry, polyamorous relationships, and families?
- What do I know about the different laws and related legal issues that plural, polygamous, and polyamorous partners and families face?

Personal Values

- How do I define "romantic relationships" or "intimate relationships" or "romantic partnerships" for myself and others? What are the differences and similarities between these definitions? Where and how did I form these definitions?
- How do I define "family" for myself and for others? What are the differences and similarities between these definitions? Where and how did I form these definitions?
- What are my views on marriage? Where and how did I form these views?
- Have I ever been or felt the need to be closeted about my partnered or familial relationships because of acceptance or pressure from legal, sociocultural, economic, and/or religious institutions?
- What are my current views on the issue of marriage equality (i.e., for same-sex or same-gender partners, for multiple partners)?
- What are my assumptions regarding the sexuality of participants in plural, polygamous, and polyamorous partnerships? Do I see the participants similarly or differently? Do I view each of them as: heterosexual, monogamous, consensually non-monogamous, non-consensually non-monogamous, gay/lesbian/bisexual, polyamorous, pansexual, omnisexual, sexually risky, etc.?
- Do I think it is possible to romantically love more than one person at a time?
- What stereotypes and prejudices do I hold about plural, polygamous, and polyamorous relationships and families?
- Do I have any friends or family who are or were members of a plural, polygamous, and polyamorous relationships and/or families?
- What are some of my preconceived notions of polyamory, polygamy and plural families? Where have I acquired these views (e.g., reality television shows, personal experience, sociocultura sl messages, religious beliefs, etc.)?
- Do I think multi-partnered relationships and families with marriages legally recognized in their home countries should be allowed to immigrate and have their current marriages/parental rights legally recognized in their new country (regardless of whether the new country recognizes multi-partnered marriages legally or not)?
- Regarding the current inheritance laws in the United States, do I think they could be altered to treat multiple (current) legal partners equally?

Clinical Insights and Practice

- What did my own family structure look like (plural, polygamous, polyamorous, monogamous, etc.) growing up and how might this affect my conceptualization of a case involving multi-partnered relationships and/or family or individuals within a plural, polygamous, or polyamorous family?
- Which therapeutic models do I typically make use of in clinical practices with partners and families? How would these models "fit" (or not) when working with plural, polygamous, or polyamorous partners and families?
- What do I see as the differences between plural, polygamous, and polyamorous families who are visible and those that are closeted? How might differences in visibility affect my clinical practice with plural, polygamous, or polyamorous families?



Departures from Monogamy

A Closer Look for Practitioners

Is monogamy for everyone? Although many consider this to be true, our research lab recently examined the potential ramifications of this presumably optimal relationship type for an individual's health and social relationships (Conley, Ziegler, Moors, Matsick, & Valentine, 2012). In this piece, we will discuss ostensible relationship satisfaction and lack of jealousy benefits of monogamy, concerns about family, and sexual safety of which practitioners may already be aware of or find useful.

Contrary to popular belief, consensual non-monogamy (CNM), including swinging, polyamory, and open relationships are not anomalies; approximately 4-5% of individuals identify themselves as part of a CNM relationship, an arrangement in which all partners involved agree to have extradydadic romantic and/or sexual relationships (Conley, Moors, Matsick, & Ziegler, 2012). Although recent media coverage has increased visibility of those engaged in CNM, these relationships are highly stigmatized. Compared to monogamy, CNM relationships are generally perceived as less satisfying, lower in relationship quality, and fundamentally flawed (Conley, Moors, Matsick, & Ziegler, 2012). In contrast, monogamy is perceived to be the ideal form of romantic relationship in our society (Conley, Moors, Matsick, & Ziegler; Perel, 2006). This is reinforced within contemporary psychological frameworks that assume dyadic partnering is universal (Conley, Ziegler, Moors, Matsick, & Valentine, 2012). Paradoxically, high rates of digression from monogamy (i.e., cheating, divorce) run counter to these assumptions about monogamy's universal desirability.

Satisfaction and Jealousy

Monogamy is often believed to provide shelter from relational insecurity and jealousy in ways that CNM cannot (Conley, Moors, Matsick, & Ziegler, 2012). In fact, the few studies that have examined this topic offer little evidence to support this claim. Research comparing gay men engaged in CNM and monogamy revealed similar levels of relationship satisfaction, closeness, and love (Blasband & Peplau, 1985). Moreover, individuals engaged in CNM reported lower jealousy than those not engaged in CNM (Jenks, 1985) and, often, described feeling positively about their partner's relationship(s) with others (Ritchie & Barker, 2006). In light of this, it seems that the assumed advantages of monogamy are, actually, not advantages at all when viewed as one of a broader range of relationship types.

What About the Family?

To many, the most basic benefit of monogamy lies in its conduciveness to raising a family. Specifically, some argue that children are best cared for by one father and one mother (see also Clarke, 2000). A currently ongoing study challenges this (Sheff, 2011; Conley, Ziegler, Moors, Matsick, & Valentine, 2012). Children of polyamorous parents mentioned similar experiences as children of monogamous parents. The children of polyamorous parents mentioned that they enjoyed receiving attention from a

variety of adults, but they missed those adults when they disappear after breakups. This can be likened to the fairly commonplace feelings of loss that children of monogamous children have when faced with divorce. This is contiguous with the idea that monogamy, in practice, may not be particularly useful for raising children.

Sexual Riskiness

Monogamy appears to be a behavior to which many aspire yet find challenging to implement; indeed, a common reason why couples seek therapy is sexual infidelity. Interestingly, and despite evidence to the contrary, our lab's research demonstrates that individuals overwhelmingly view monogamous relationships as disease-free and people perceive individuals engaged in CNM as more likely to spread sexual diseases (Conley, Moors, Matsick, & Ziegler, 2012).

However, sexually unfaithful individuals (those in monogamous relationships who admit they have cheated on their partner) were less likely than individuals engaged in CNM to use barriers during their extradyadic encounter, tell their "monogamous" partner about the encounter, and get tested for STIs (Conley, Moors, Ziegler, & Karathanasis, 2012). Additionally, sexually unfaithful individuals were less likely to implement safer sex strategies with their "monogamous" partner than individuals in CNM relationships. Our lab also found that sexually unfaithful individuals were more likely to make condom use mistakes (e.g., putting the condom on the wrong way) than individuals in CNM relationships during their most recent extradyadic sexual encounter (Conley, Moors, Ziegler, Matsick, & Rubin, invited for resubmission). These findings suggest that CNM may provide a safer avenue for sexual expression than failed attempts at monogamy.

Looking Ahead

Taken together, this research highlights that CNM relationships can be viable and successful options—despite stereotypes that suggest otherwise. In light of this evidence, we, as basic and applied psychologists, have the potential to disarm stigmatization of CNM relationships and spark constructive conversations about alternative relationship styles. As it is today, preference and choice may have taken a back seat to tradition. More open dialog offers hope for a future where monogamy is not a default; instead, a relationship type can be chosen based on merit, personal inclination, or planning. In the end, it is important that we understand that monogamy may not be for everyone or the safe haven that previous research implies.

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Kelly Grahl is research project coordinator in Dr. Terri Conley's Stigmatized Sexualities Lab. Grahl has worked closely with his advisers to contribute to research which increases understanding of consensual non-monogamous relationships and the stigmatization of sexually transmitted infections.

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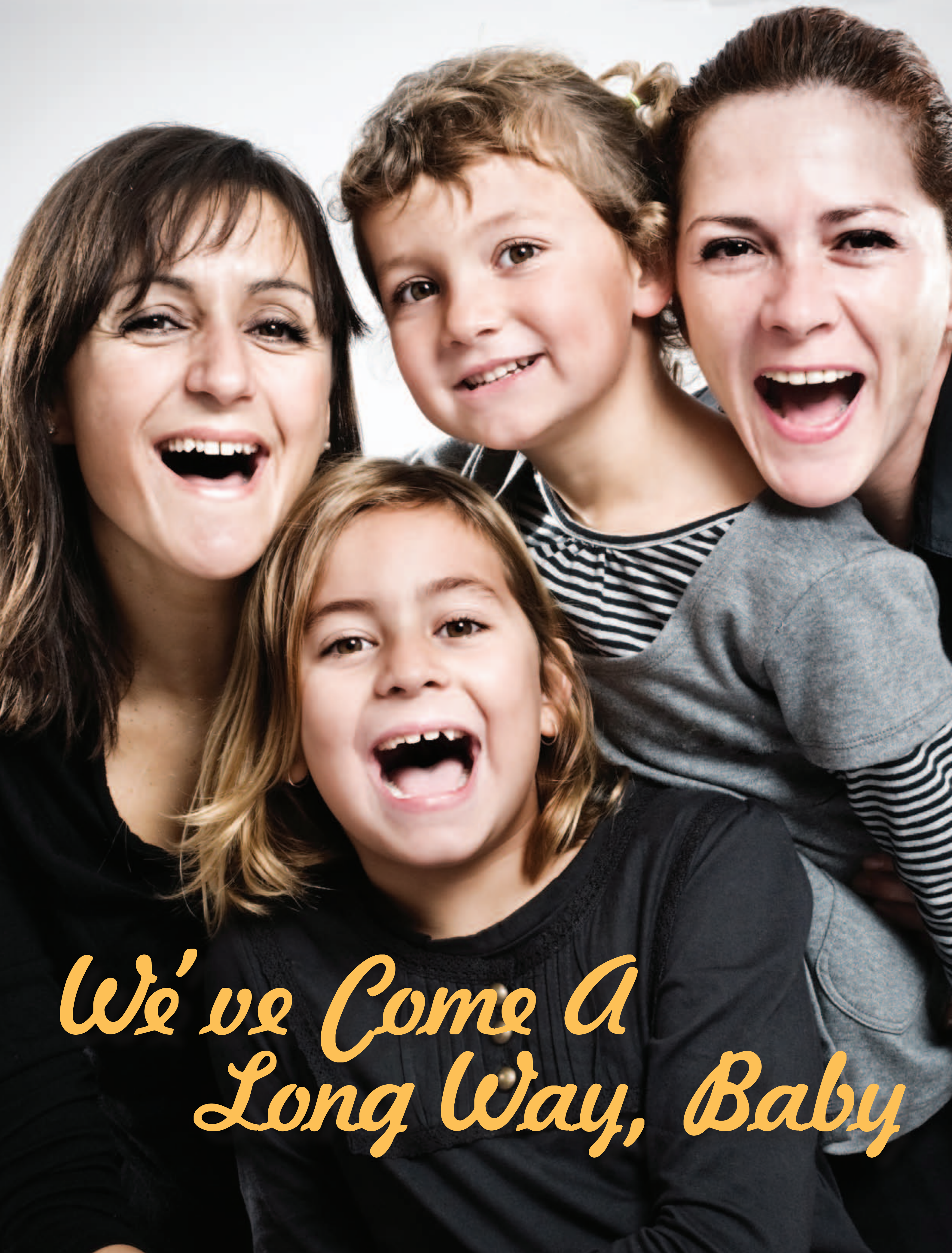
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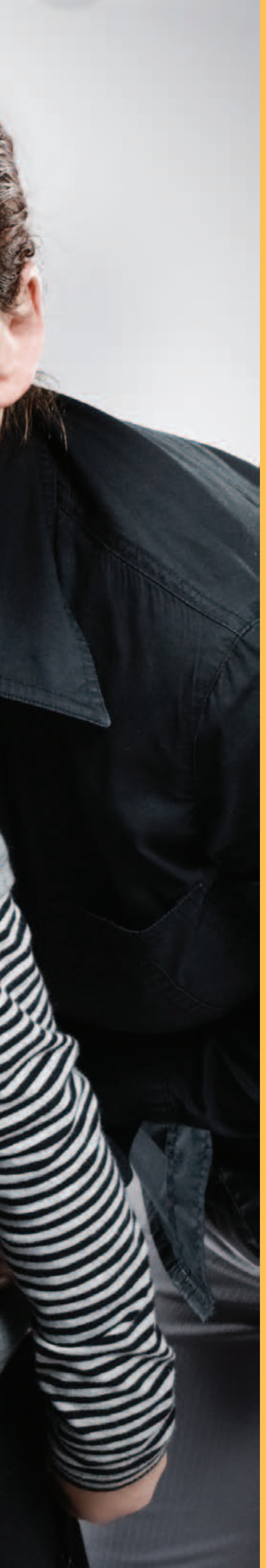
Long Way, Baby



Times Are Changing for Same-sex Parented Families.

These are exciting times to be a marriage and family therapist. Not because of healthcare or diagnostic changes. To be an LMFT today is to work with one of the most richly diverse populations in our history—the family of the 21st Century.

The way in which we are called to do therapy is changing. Family no longer looks the same or is defined the same as it was even a decade ago. We can call them atypical, alternative or unconventional, but whatever we're calling family, **it's unprecedented.**

MaryAnne Banich Massey, EdS

One of the most rapid changes we've seen in the family structure is in same-sex parenthood. It's a Gayby Boom. According to the U.S. Census Bureau (2011), there are 115,000 gay and lesbian couples parenting children. That's double the number from 10 years ago. And The William's Institute at UCLA's School of Law (Gates, 2013) estimates the number of children living with gay and lesbian parents (both couples and single parent households combined) is about 1.6 million. In Canada, the 2011 Census counted 64,575 same-sex couple families. Of these couples, 21,015 were same-sex married couples and 43,560 were same-sex common law couples (Statistics Canada, 2011).

Matt and Michael met in California in 2001 and moved to South Carolina in 2004 for Matt's job. Michael decided he no longer wanted a 9-5 career, and once they felt settled in a new home and lifestyle they started talking about expanding their family.

"We began in 2006 or 2007 with books, the internet and talking with people," Michael said. They considered all the options: private adoption, agency adoption, international adoption and surrogacy. "We sought the advice of an attorney and the information we got was very discouraging," Matt said. The information turned out to be incorrect.

"We were told domestic adoption would be impossible, when, in fact, it's less homophobic than international adoption. There are countries like China, for instance, where the adoptive couple is asked to sign an affidavit that they are not gay or lesbian," Michael said.

They also were told one of them would have to be the adopting parent and they would have to list the non-adopting partner as an "other adult living in the household" no matter how they chose to adopt. This felt like beginning their family under a shroud of dishonesty and secrecy and they didn't want to do that.

> "We have a lot to learn from them as heterosexual couples." - JULIE SCHWARTZ GOTTMAN

In a not-so-distant past, the words gay and lesbian were deemed contradictory to the definitions of father and mother. Gay and lesbian parenting was seen as abnormal and atypical at best, and deviant at worst. But the desire to parent is not reserved for the heterosexual male and female.

Couples therapist Julie Schwartz Gottman (personal communication, March 15, 2014) says it's important for us to remember that homosexuality was taken out of the *DSM* (American Psychiatric Association, 2013) 40 years ago. "It's been removed from any diagnosis. It's simply another way of love."

Indeed, the common stereotypes of gay and lesbian parenthood are not supported by the research. Schwartz Gottman reported that a 12-year-long study of gay and lesbian couples showed that in most cases, they have more relationship strength than heterosexual couples, are more reasonable, they are more transparent about feelings and more honest with each other. "We have a lot to learn from them as heterosexual couples."

Her research (Gottman, 1989) of daughters raised by lesbian moms examined gender identification, sexual orientation and 18 scales of social adjustment in comparison with daughters raised by heterosexual single moms or re-married heterosexual moms. The study showed no significant difference between the three groups, daughters of lesbian moms were mostly heterosexual, normally feminine, and most importantly, daughters of lesbian moms who raised them with lesbian partners show a stronger sense of well being and independence than daughters of single, heterosexual moms who raised daughters alone.

Professor of psychology at the University of Virginia, Charlotte Patterson, agrees in her article, "Lesbian & Gay Parenting," for the American Psychological Association. "Research has failed to confirm the three historically held beliefs about gay and lesbian parents." Patterson writes those three concerns have been the belief that lesbians and gay men are mentally ill, that lesbians are less maternal than heterosexual women, and that lesbians' and gays' relationships with sexual partners leave little time for ongoing parent-child interactions.

Having a biological child was not as important to Michael and Matt as bringing a child into their home who needed one. "And surrogacy was cost-prohibitive for us, so we decided on adoption," Michael said.

One of the resources Michael and Matt took advantage of as they maneuvered their way through the adoption process was the Human Rights Campaign (HRC). "That's the website where we found our adoption agency IAC (Independent Adoption Center)," Matt said. Many of the other adoption agencies had religious ties and the couple didn't want to experience discrimination in the already complex process of growing their family. "We

found them to be very gay friendly. For them, gay and lesbian couples were not an after-thought as potential parents," he said.

For "Sherry" and her partner, creating biological children together was important. "We really didn't consider adoption," she said. The two women who had been together four years at that point took a year to research their options including health plans and potential fertility specialists in the area who would accept same-sex couples.

"We found the company we ended up using to help us find our sperm donor at an LGBT expo," Sherry noted. The two researched Xytex Cryo International Sperm Bank comparing them with other similar companies and ended up choosing them. The couple was put on a waiting list for the particular donor Sherry and her partner chose. When he became available again, they purchased three viles and had Xytex store them until they were ready for insemination. The couple tried conception three times, but never were able to conceive. Sherry and her partner are no longer together.

In a 2009 survey, published in *The American Journal of Family Therapy*, of therapists in the United States, 50 percent of LMFTs reported not feeling competent to treat gay and lesbian clients (Green, Murphy, Blumer, & Palmanteer).

In Frederick Bozett's book, *Gay and Lesbian Parents*, published in 1985, D. Dulaney and J. Kelly posit that homosexuality is neglected as a population in training human services professionals. "Students should have practical experience in the area of sexuality directed by expert faculty so that when they are full-fledged practitioners they are better qualified."

Schwartz Gottman agrees and said, "there should be specific sensitivity training taught by gay and lesbian therapists to teach empathy and understanding of gay and lesbian families. Also there needs to be a program that teaches therapists to own their own biases of gays and lesbians." She said The Gottman Institute created a separate lesbian couples group and a separate gay couples group, even though gay and lesbian couples had been participating, and still do, in their mostly heterosexual couples groups.

The biological mother communicated with Michael and Matt throughout her pregnancy. "When we got the phone call she was having twins, that was exciting," Michael said.

The couple was able to fly to California, the birth state,12 hours after the girls were born. "At the hospital, both biological parents, as well as maternal and paternal biological grandparents, were there for the birth," Michael said.

Michael and Matt had to have an interstate compact (all states and the District of Columbia have an interstate compact that assures that children moved from one state to another in their adoptive or foster care placements receive an appropriate level of care—this not specific to gay and lesbian parents) to be able to bring the twins back to South Carolina.

Some states have a second parent adoption law for any couple living together and unmarried, which means one can be the legal parent and the other can adopt. Otherwise, the other parent cannot adopt. "In that case, there would be no legal guardianship of the children for both of us," said Michael. "I felt that would be being secretive and not honest if I presented myself as the legal guardian to healthcare professionals, daycares, schools, etc."

Through diligent research, the couple found a way for both of them

Co-Parenting Agreement

For co-parents who want to have legal parental rights and responsibilities for a partner's child, a co-parenting agreement is a legal document that can be used to clearly explain the rights and responsibilities of each parent where a second-parent adoption is not available.

A second-parent adoption extends legal parental rights to the non-biological or non-adoptive co-parent. However, some states' laws not only restrict who may adopt a child, but also ban second parent adoption. If partners do not have access to second-parent adoptions, a co-parenting agreement may be the best legal option.

In the co-parenting agreement, partners may:

- Agree to jointly and equally share parental responsibilities by proving support and guidance to the child(ren)
- Authorize the other to consent to medical care for the child
- Devise a custody agreement before any separation should one occur
- Stipulate that each partner will name the other partner as the child's guardian in his or her will

Custodial parents can stipulate in the will that they want the partner to become the child's guardian in the event of death, but this stipulation is not legally binding in a court of law.

Source: Human Rights Campaign

to have legal guardianship and for both of them to be listed on the birth certificate as the parents. "By finalizing the adoption in a state (California) that allows out-of-state couples to adopt in that state (CA has second parent adoption), South Carolina has to recognize both of us as the legal parents," Michael explained.

The couple married in California during the gap between the judge giving couples permission to legally marry in California and the referendum taking the right away. South Carolina (the state in which they live) does not recognize their marriage, but family court has precedence for dealing with custody of biological parents, not being married, so because they both are named on the birth certificate as equal parents, that is how the courts would deal with any family law issues.

Because it was important for Matt and Michael to have no secrecy or dishonesty throughout this experience from the beginning, they presented themselves as a couple. "We have an open adoption, meaning the biological parent, as well as the adoptive parents, choose each other in a matching process. We meet and are then able to negotiate the terms of the adoption," Michael said.

The couple decided it is important to normalize the adoption. They have a photo book of the biological mother that has been available to the girls since around their first birthday. "I actually talked with friends who were adopted and asked them what they wished they'd had," Michael said. "One of the things was a photo of their mother when she was pregnant with them. I made sure the girls have one of those."

The twins' last name is a hyphenated version of Michael's and Matt's to cut down on questions of their relationship to the girls. Michael knew he would be the one most likely to deal with healthcare providers, schools, etc. where there could be a question of legal guardianship. "But we now don't think that was actually necessary," Matt said.

The twins are five and a half years old now. The couple hasn't encountered any issues with people assuming one of them is the parent and the other of them is not. "We have encountered people assuming we are two dads giving our wives the day off," they laugh.

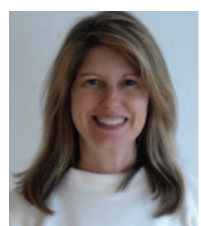
They did run into other stereotypical assumptions that parenting is the woman's job, though. When Michael asked to join a multiples club in the area, for example, they had to change their bylaws to let him join because the definition of member was "a mom." Michael proposed this could happen with a heterosexual couple if dad was the main caretaker at home and mom the out-of-the home provider.

"We do keep running into mom being the nurturing, loving parent and dad not involved much except as the out-of-the home provider," they said. It is difficult for them to find examples (books, TV shows) to normalize for the girls that they have two loving, stable parents just like everyone else.

In 2013, Michael and Matt started paperwork with South Carolina's social services department to adopt again. "There have been significant changes since 2007," Michael said. "There is no more tentativeness with gay and lesbian couples," Matt said. They have been treated as if they are a married couple. (They are married but South Carolina does not recognize it.)

Michael thinks gay and lesbian people imagine roadblocks and self-police when they shouldn't. "The perception might be they will be discriminated against, but that might really not happen," he said. Matt says same-sex parents need to act like it's normal and other people will, too, and treat them and their children like everyone else.

The good news is even though the face of the family is changing rapidly, much of society is adapting. Things have changed a lot for the better in the past seven years since the couple first started their quest for same-sex parenthood.



MaryAnne Banich Massey, LPC is a Member of AAMFT and in private practice in Columbia, SC. She has ten years of practice experience and her areas of speciality include parenting and family concerns, and gay and lesbian issues.

Note: Matt and Michael are a local couple in Columbia, SC, who agreed to be interviewed on the condition of anonymity.

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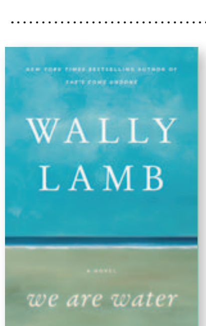
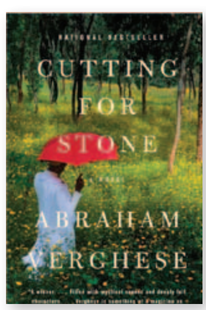
The relationship between reading fiction and developing interpersonal skills is a hot topic in psychology news in 2014. Therapists are suddenly picking up novels for more than just self-care, and they are finding they can learn as much about the human condition from fiction as they can from their clients. **Here are some recommendations for diverse families in fiction.**

Kathleen Smith, MA

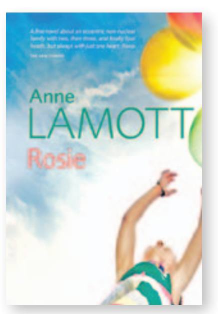


Wally Lamb is no stranger to writing about the world of mental health, and in his latest novel, *We Are Water*, he has imagined a family quite unlike any other. A master painter with a buried past and her psychologist ex-husband struggle to connect on the eve of her same-sex wedding to her wealthy female art dealer. Told in alternating voices of the family members, Lamb's work also explores the lives of their adult children, whose religious beliefs and failed relationships drive their curiosity to understand the history of trauma hidden in the family's past and to salvage a sense of hope for future generations.

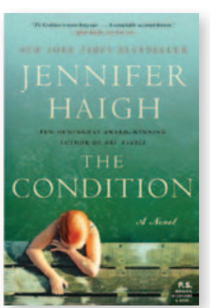
When author **Heidi Durrow** moved to a racially divided town at the age of 11, people were always stopping to ask her why she had light brown skin and blue eyes. Harnessing her experiences living in a multiracial family, Durrow wrote *The Girl Who Fell From the Sky*. Her debut novel tells the story of young Rachel, who must learn to live with her strict African American grandmother after the unthinkable occurs. Set in the 1980s, a grieving Rachel faces the challenges of identifying as a biracial woman when the world wants to label her as black or white.



Cutting for Stone is often categorized as a great love story or book every doctor should read. But at its heart, **Abraham Verghese**'s masterpiece is a family saga, one that guides the reader through a voyage of rupture and reconciliation. Twin brothers who were once joined at birth come of age as Ethiopia teeters towards collapse, and each must face the impact of their Indian mother's death and their British father's desertion on their interwoven fates.



Better known for her non-fiction, the astute and irreverent **Anne Lamott** writes from the perspective of a nine year old and her widowed mother in *Rosie*, first in a series of three books about the Ferguson family. Witty and surprising, the novel follows a mother's uphill battle to protect her inquisitive daughter from the dangers of the world. She must also hold the demons of alcoholism at bay, as she considers expanding her family to a third.



New York Times Bestselling Author **Jennifer Haigh** explores the impact that genes can have on family mythology in her novel, *The Condition*. Heroine Gwen McKotch is diagnosed with Turner's syndrome, a condition that ensnares her in the body of a child throughout her adult life and causes her to become a social recluse. Told from multiple family member perspectives, the story captures the denial and disenchantment of the McKotch family as they wade through the aftermath of a two-decades-past divorce.

For more recommendations, ask your colleagues about what novels have motivated them to think differently about their own work and the lives of others, both real and imaginary. There is truth in story, and fiction can strength the muscles of empathy and understanding as easily as the person sitting across the room of your office.

AAMFT Resources on Family Forms and Diversity

All content listed can be accessed through www.aamft.org.

Family Therapy Magazine

March/April 2002: Culture and Color
Covers topics of race, diversity, racial disparities, and cultural competence

May/June 2004: Adoption
Covers topic of transracial adoption

January/February 2005:
Family Therapy Around the World
Highlights family therapy work around the world, including Japan, Serbia, Mexico, Russia and Argentina

November/December 2005:
Gay and Lesbian Relationships
Covers gay and lesbian couples, G/L families, sexual categorization, transgender youth, same-sex oriented youth, and coming out

January/February 2006: Reproduction
Discusses in vitro fertilization (IVF) and embryo freezing, egg and sperm donors (third party reproduction), and surrogates

January/February 2008 - Immigration
Includes guidelines for working with immigrant Muslim families, therapy with immigrants in Canada, Latino immigrant families, and more

Clinical Updates

Family Therapy with Same-Sex Parents and Their Children

Grandparents Raising Grandchildren

Therapy for People Who Live in Stepfamilies

Multiracial Families

Sexual Minority Youth—The Role of Family Therapists

Transgender in Family Therapy

Same-sex Couples

Clients can access information on any of these topics at www.aamft.org/therapytopics.asp.

Journal of Marital & Family Therapy contains approximately 200 articles on these topics. Type keywords on the JMFT page to search for articles on diversity topics and family forms.

Student Reflections

Defining the LGBTQ Family (And Being Content Without an Answer)

Caetlyn L. Carroll

"…there is nothing morally wrong about wanting a child and doing everything in your power to have one."

This quote came from my sister, who identifies as lesbian, during an interview I conducted with her recently for the purpose of this article on the topic of LGBTQ parenting. As was made evident during my discussion with her and after continuing my research on the topic, there seems to be a mainstream idea of family that often causes feelings of invalidation for LGBTQ individuals.

Before I discuss my thoughts on the definition of family, I invite you to explore your own conceptions of the term. Is there a difference between two committed individuals living under one roof versus two committed individuals raising their children? The vast majority of us would agree more with the latter in their definition of family, following the culturally accepted view of family as a group of three or more individuals most often of common ancestry or shared biology. Merriam-Webster (2014) would go so far as to call the family a "basic unit in society traditionally consisting of two parents rearing their children."

This leads to my second question: What is a "parent"? When I asked this question to a couple in my family who identify as gay, this was their response:

"A good parent provides unconditional love and support, joy, boundaries, security and encourages compassion, empathy, kindness and a positive self-image/self-worth. A good parent provides a guiding hand, but allows the child to find their path to happiness. A good parent understands the responsibility they have undertaken because their child is going to go out into the world, so it is imperative to make sure that their child has a positive effect on the world they share with so many others."

Such simple terms that one often wouldn't think twice about are actually two very complex terms to define, particularly in today's society where the "traditional nuclear family" no longer consists of a stay-at-home mother, overly-worked father, and two children of opposite gender. So why is this still the ideal family form? My sister, like many others, hopes one day to have at least one biologically connected child with "the whole big yard and white picket fence scenario." LGBTQ parents, as with heterosexual infertile or adoptive parents, find themselves negotiating with non-biological relatedness (Ryan & Berkowitz, 2009). These couples must confront heterosexism along with their limitations of physiology. In our society, biological relatedness and heterosexual dominance is a privilege that shapes the choices and experiences of LGBTQ parents (Ryan & Berkowitz, 2009). This is emphasized in a world where there are too many children hoping to be adopted, while we focus so much attention on the advancements in reproductive technology. As termed by Ryan and Berkowitz LGBTQ couples go through a "relational infertility." On top of the difficulties associated with conception or adoption, these couples must do their best to guarantee fair treatment (free from bias or homophobia) from adoption caseworkers or medical professionals.

My sister's quote is just one example of how motivated LGBTQ individuals may be to come as close as possible to society's genetically-based family ideal. Today, LGBTQ couples have children through heterosexual marriages, alternative insemination, adoption/foster care adoption, or through complex parenting arrangements. Regardless of which path they choose, there are always a plethora of difficult decisions that must be made.

Perhaps the most challenging obstacle on the road to parenthood for LGBTQ individuals is the legal system. States

vary in their laws regarding LGBTQ rights to adopt and difficulties arise when one partner decides to provide their own genetic contribution to be medically combined with that of a donor. When one or both partners lack a biological connection to the child, they often lack legal parental rights and fear that a birth parent can re-gain rights over the child (Ryan & Berkowitz, 2009). Often times, LGBTQ parents undergoing donor insemination will choose donors who closely resemble themselves or their partner. Having an actual or apparent biological connection to one's child adds a sense of legitimacy to the family because it more closely aligns with the family ideal. This also allows parents to feel closer and more connected to their children (Ryan & Berkowitz, 2009). My sister describes the following:

"My ideal scenario would be to use artificial insemination to conceive the child. Though it is extremely expensive, I imagine using either mine, or my partner's, eggs and placing the insemination into the opposite partner. That way, both of us are equally involved in our child's life right from conception."

The desire for a woman to experience pregnancy is another way to ensure a type of "biological connection" to the child. LGBTQ individuals must do their best to maintain the intimacy and affection involved in the process of bringing a child into the family, which will require the reproductive assistance (in one way or another) of parties outside of the couple (Ryan & Berkowitz, 2009).

Opponents of LGBTQ rights to parent commonly believe that a parent's sexuality is relevant to their parenting capacities and that being a gay or lesbian parent has an adverse impact on children. These views stem from the prior belief that homosexuality is an illness to be cured. Early psychoanalysts would argue that the lack of both a mother and father figure in infancy and young childhood leads to disruption of child personality development (Patterson, 2009). But who's to say that there cannot be a positive male or female role model in the child's extended family or parents' social network? The following words come from the couple who earlier provided their definition of a good parent:

"A parent is a parent regardless of their sexual orientation. We do not separate a homosexual parent from a heterosexual parent. If a child is raised in a healthy, loving home, regardless of if they are raised by a mother/father, mother/mother, father/father or a single parent, that child will flourish. What matters is how a child is raised, not who raises them."

The idea that gay individuals are estranged from their families of origin is another common LGBTQ stereotype (Patterson, 2009). Many times, even if parents of LGBTQ individuals are not overly supportive of their child's alternative lifestyle at first, support increases after the child has children of his or her own.

For an LGBTQ individual, the decision to become a parent is almost always intentional and planned, due to obvious biological restrictions. Personal considerations, parental support networks, work-related issues, and intimate partner relationship qualities all play a role in the decision to become a parent or remain childless (Mezey, 2013). As a group, LGBTQ people are less likely to become parents due to financial and biological barriers. However, researchers Riskind, Patterson, and Nosek (2013) have discovered that those individuals identifying as LGBTQ are often more optimistic and confident about adoption or fostering. Younger individuals in particular are better able to see more positive outcomes for children of LGBTQ parents (Riskind, Patterson, & Nosek). This is a demonstration of how times have changed, as younger generations seem to be much more accepting of alternative lifestyles and the decision to parent.

As a graduate student with only six months of direct clinical experience, I have already started to develop my own set of guidelines for how I'd like to approach certain issues with clients now and in my future practice. A relationship contract is a great tool to utilize with couples who are negotiating roles and expectations in their relationship. If I am lucky enough to meet with the couple before they go through a marriage or the transition into parenthood, this tool can be stored in a safe place and used as a reference for future discussion. LGBTQ individuals, like any others about to take the leap into marriage or parenthood, can work alongside of the therapist to plan for division of household tasks and childcare responsibilities. Prior research has determined that lesbian couples generally have higher relationship satisfaction and a more equitable division of household and childcare tasks than either gay or heterosexual couples. Some clinicians link this higher satisfaction to more positive child outcomes (Patterson, 2009).

It is natural for LGBTQ individuals, or any individual, to have concerns about entering into a new relationship, either as a partner or parent. A good clinician will help clients explore their fears and bias by examining internalized homophobia. What is heard in society

and through religious values may conflict with one's personal life, causing added anxiety. By emphasizing that integration and acceptance of societal/religious values is an ongoing process, we can help clients better understand that the work will never completely be done. Including outside supports (such as family members or friends) in therapy can help prepare clients for a variety of positive and negative reactions to certain scenarios (Halstead, 2003). This is initially safer in a therapeutic atmosphere before later shared in the larger society.

Most people want to become parents because of the perceived emotional rewards and personal fulfillment. For heterosexual couples, there are social pressures pushing these individuals into parenting roles, and stigma accompanies those who decide not to parent. Homosexual individuals face the opposite, feeling pressure to remain childless. For them, becoming a parent is a matter of overcoming multiple barriers. When these individuals feel higher confidence in their potential abilities to parent, they are more able to make informed choices about parenthood and therefore more likely to accomplish the difficult transition into parenthood (Riskind, Patterson, & Nosek, 2013).

A major theme surrounding the entire issue of LGBTQ parenting is identity. LGBTQ individuals will constantly be faced with questions about their identity, more so than heterosexuals. When society places such strong emphasis on the dominant sexual orientation, physiological abilities related to gender, marital status and parental status, what is left for LGBTQ individuals to draw on? There is constant invalidation, and this will only continue to have a generational influence on the children of LGBTQ individuals, who will likely go through a point where they question their own biological histories. I hope that this opens up more possibilities for exploration and encourages them to truly express themselves and live up to their morals in a more genuine, non-judgmental manner.

I have learned a lot in my current masters program, but most importantly, I've learned to keep an open mind and continuously challenge "normative" definitions of family and parenthood. Parents of any gender or sexual orientation will be criticized for their parenting choices at one time or another. There is no set script for parenting, which makes the job that much more challenging. Our society is a long way from developing a "multicultural ideal" (Ryan & Berkowitz, 2009) for parenting, and heterosexual dominance will continue to guide our parenting decisions. In a generation that looks so closely for answers and definitions, we have to learn to be ok with ambiguity.

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Insights to Transgendered Youth

Reece Malone, DHS

Transgender and gender non-conforming people face injustice, discrimination and prejudice in every systemic facet of their lives. Some of the daily stressors faced by transgender and gender-non conforming people include: accessing primary healthcare, participating in educational institutions, inclusion at gendered shelters and housing, navigating the legal system, obtaining meaningful and equitable employment and safely accessing public washrooms. Despite these very adult intersystemic realities, we see more transgender identified and gender non-conforming youth emerge with a strong sense of identity, social justice, citizenship, and social responsibility.

While rates of depression, anxiety, suicide ideation and completion remain disproportionately high, we see more transgender and gender non-conforming youth take on leadership roles, initiate school-based programming, and cultivate meaningful relationships with peers. As individual and family therapists, it is fundamental that we identity some of the factors that cultivate resilience and promote the right to self-determination without repercussion.

Transgender is an umbrella term or identity for those whose gender identity intersect medical conventions of sex and/or cultural constructions of maleness and femaleness. Individuals may or may not identify as transgender depending on a constellation of factors such as: safety, risk of discrimination and violence, personal ethics and values, or the inability to live stealth—should stealth be a goal. Gender non-conforming refers to the degree of adherence to culturally and socially constructed expressions of gender. Furthermore, transgender and gender non-conforming individuals may or may not seek medical interventions to affirm their identities; an assumption by popular culture that reinforces gender dualities rather than acknowledge gender spectrums. We see more individuals disrupting gender identity constructions by identifying as genderqueer, ambigendered and pangender, and use gender neutral pronouns including they, them, yo, ze, and hir. We also see those who are embracing their Indigenous heritages by identifying as Two-Spirit, one of a few non-colonized identities capturing the gift and sacredness of the embodied genders. For this article, the terms transgender and gender non-conforming will be used acknowledging the challenges of capturing the diversity of gender identities that exist beyond man, woman, male and female.

Matt, age 16, explains his daily routine:
I wake up and immediately I'm mis-IDed by my parents who refuse to call me Matt and only call me by my birth name. I'm mis-IDed by my sister too who constantly screws up my pronoun. Then I get on the bus and I'm mis-IDed by the driver. At school even though I look male, act male and ID as male, most of the teachers keep mis-IDing me. I'm mis-IDed again when I go to the bathroom and told that I can't use the boy's bathroom. At the cafeteria, the serving staff mis-ID me. After school, I get back on the bus and am mis-IDed, I go to the mall and am mis-IDed because I'm wanting to try on guy

clothes, then mis-IDed when I get on the bus to get home. I'm then mis-IDed by my parents and sister when I get home. I think that's about 15 times that I'm mis-IDed and I haven't even had supper. Every time I'm mis-IDed, it feels like little deaths over and over.

When asked where Matt finds strength and courage to be his authentic self, he acknowledges a strong support network of friends whom he sees regularly, especially at his school's Gay/Straight Alliance (GSA) club, as well as support from the GSA teacher supervisors. "I just told my teachers that my name is Matt and I go by 'he' and since then, they've never ever slipped up." He takes on a leadership role by coordinating school fundraisers and is engaged in his local lesbian, gay, bisexual, transgender, two-spirit, queer (LGBTTQ) youth group by providing peer support.

The most successful interventions a family therapist can provide youth is a participant-centered approach that honors names and pronouns, an environment that is safe for a youth to either "be" or explore gender, the chance to experience multiple pronoun changes and a practice that rejects the pathologization of gender identities. When transgender youth are engaged in meaningful relationships with allies, it builds their self-esteem, resilience and sense of cultural and social belonging. Studies show that transgender youth whose identity is affirmed and supported report lower rates of stress and self-stigma in comparison to youth who withhold their identity. Family therapists can help navigate disclosure, build coping strategies, provide resources and share harm reduction principles.

Today more transgender and gender non-conforming youth are disclosing or selectively expressing their identities to their families, schools, peers, case workers, health professionals, and family therapists. Despite the risks associated with disclosure, they are choosing authenticity despite the criticism, judgement and social isolation they continue to endure. It is imperative that family therapists meet youth where they are, wherever they are on the gender spectrum. This process includes acknowledging transgender youth beyond deficits, and to proactively explore and implement processes that honor chosen names, pronoun identifications and self-determination, access to public services including gendered spaces, and cultivate community connections. We need to truly listen to trans youth and they need to be heard.

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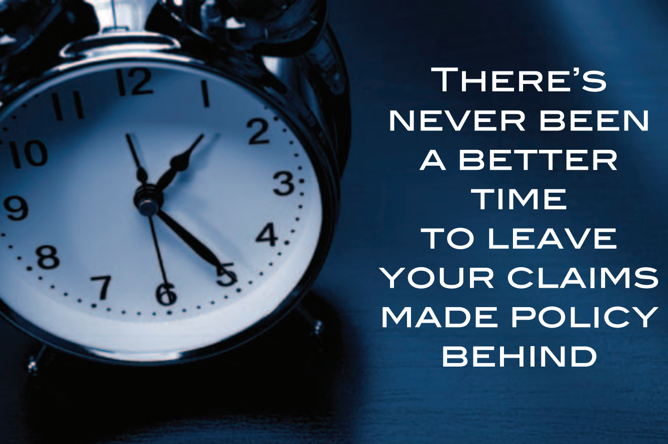

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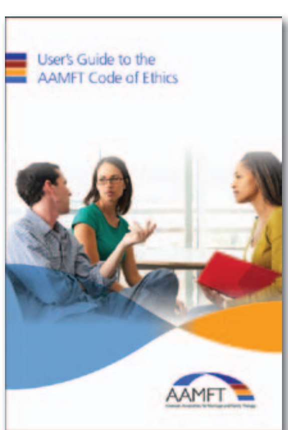

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